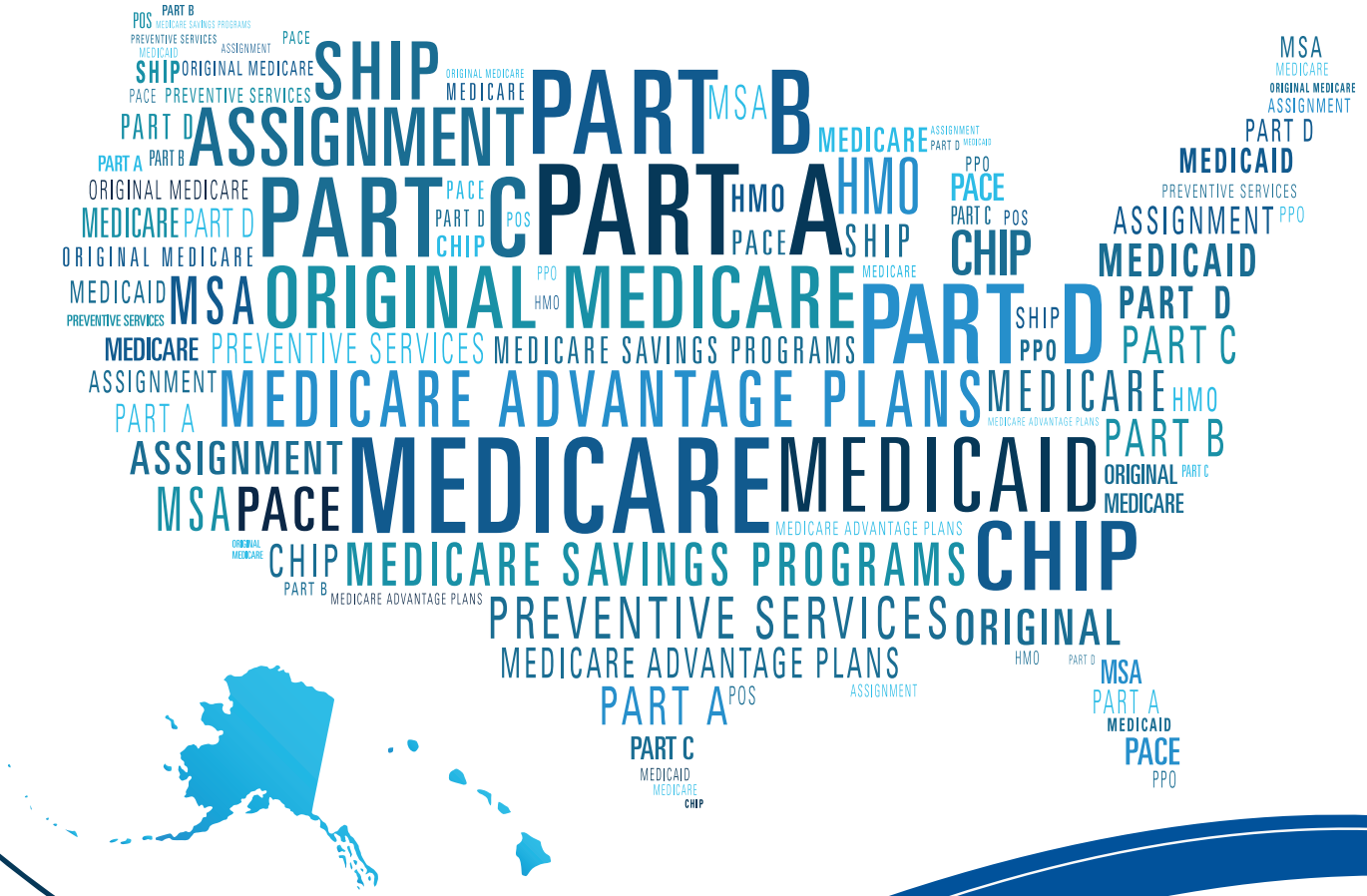
CMS NTP NATIONAL TRAINING PROGRAM

Medicare 101 WORKBOOK



2017

DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

This workbook from the Centers for Medicare & Medicaid Services (CMS) National Training Program (NTP) is an informational resource for CMS partners. It is not a legal document or intended for press purposes. The press can contact the CMS Press Office at press@cms.hhs.gov. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

Additional information and resources from the CMS NTP are available at https://www.cms.gov/outreach-and-education/training/cmsnationaltrainingprogram/.

July 2017

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About Medicare 101

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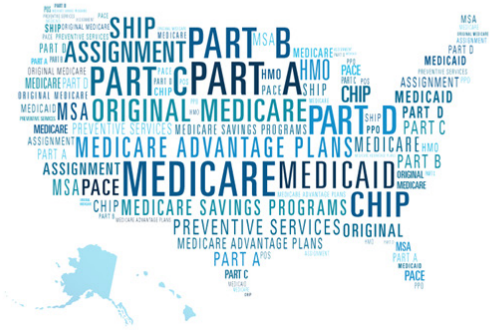

Medicare 101

2017

About Medicare 101

Medicare 101 is a training module from the Centers for Medicare & Medicaid Services (CMS) National Training Program. The module and this complementary workbook explain the Medicare Program, including what it is, coverage and costs, coverage choices, enrollment, coordination of benefits, and how to fight fraud, waste, and abuse.

The Medicare 101 training module was developed and approved by CMS, the federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Federally-facilitated Health Insurance Marketplace.

The information in the Medicare 101 training module and this workbook was correct as of July 2017. To check for an updated version, visit https://www.cms.gov/outreach-and-education/training/cmsnationaltrainingprogram/index.html.

Additional training modules are available at https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Classroom-Modules.html

How to Use This Workbook

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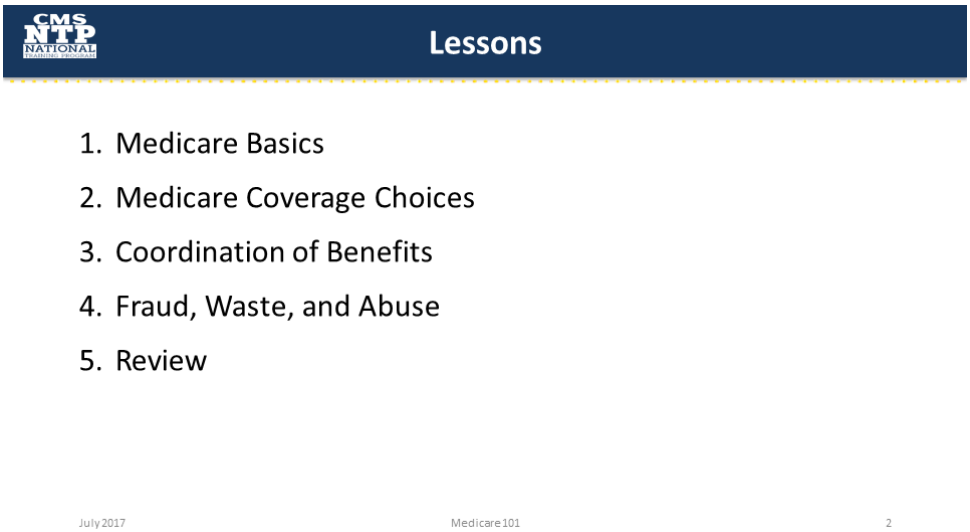
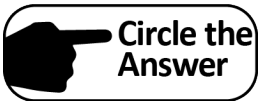


How to Use This Workbook

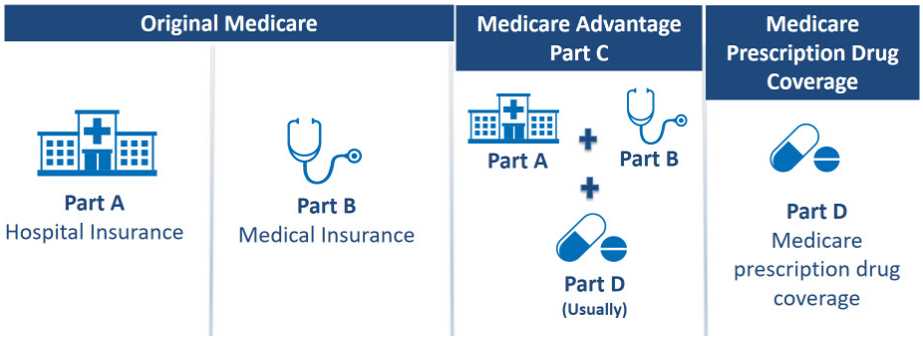
What's inside. The *Medicare 101 Workbook* complements the Medicare 101 training module. Medicare 101 is an overview of the Medicare Program. Additional detailed training products on topics such as rights and protections, Medicare Supplement Insurance (Medigap) policies, Medicare Advantage Plans, and Medicare prescription drug coverage are available for download at CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Classroom-Modules.html.

The workbook is organized to correspond with the content of the Medicare 101 training module. It includes space for note taking, as well as appendices with links to additional resources for training and reference, a glossary of Medicare terms, answer keys for activities included throughout the workbook, and a quick reference guide to common Medicare questions.



Wherever you see a pointing finger icon, you'll find activities such as match games, fill in the blanks, circle the answer, and true or false questions. These activities may be done during live training sessions or individually. The answer keys are in Appendix C.

Wherever you see a logo like this, you'll find a link to an online CMS Classroom Module. These modules are self-paced individual learning tools that cover a particular Medicare 101 topic in greater depth. Appendix A includes descriptions and links to all available CMS Classroom Modules.



The icons in this chart are used to indicate the 4 parts of Medicare. Throughout the workbook, these icons are used for Part A, Part B, Part C, and Part D.

Ideas for Trainers

- Direct participants to complete selected activities in the workbook during or after a training event.
- Remind participants that there will be a review activity at the end (Lesson 5). Call attention to content that will be included in the review. These reminders will be motivating for participants who enjoy friendly competition.
- Refer participants to pages within the workbook for additional information or resources on topics not fully covered during the training. This will help them see what's in the workbook and understand its value as a reference.
- Encourage participants to take notes in the workbook. Writing will help them remember key points.
- Encourage participants to keep the workbook as a reference tool and to use the activities and suggested resources to further their learning.

Ideas for Participants

- Take notes in the workbook during the training event.
- Retain the workbook as a quick reference tool.
- Complete the activities in the workbook to check your understanding.
- Explore the resources in Appendix A to further your knowledge about Medicare.

Lesson 1—Medicare Basics

[Slide 3]

Lesson 1 covers Medicare basics, including the following topics:

- What is Medicare?
- What Agencies Are Responsible for Medicare?
- What Are the 4 Parts of Medicare?
  - What Is the Cost and Coverage of Part A?
  - What Is the Cost and Coverage of Part B?
- When Can You Appeal?
- How and When Can You Enroll in Medicare?

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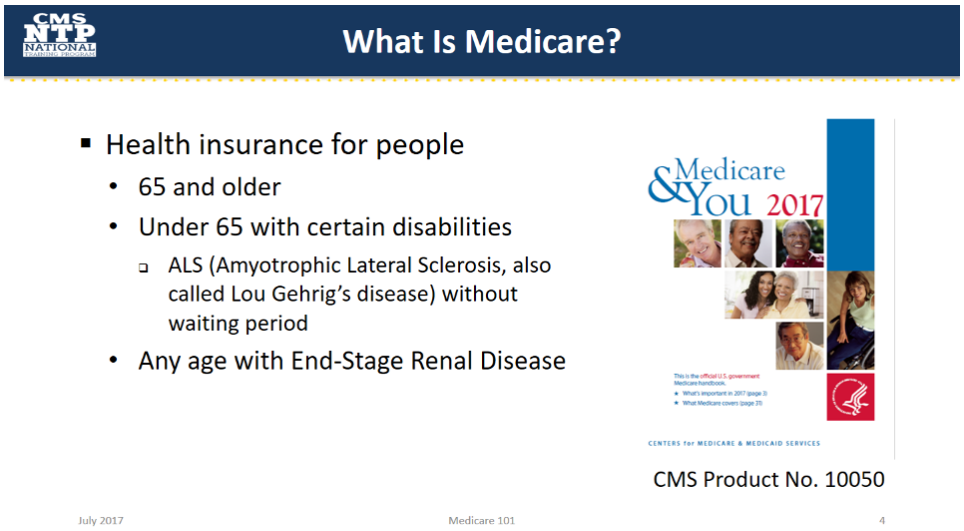

What Is Medicare?

Fill in the Blanks

Choose from the response options. See Appendix C for the answer key.
Response options: *65, 1, 24, 57.7*

Who's insured. Medicare is health insurance for generally 3 groups of people:

- Those who are _____ and older
- People under 65 with certain disabilities who have been entitled to Social Security disability benefits for _____ months—includes Amyotrophic Lateral Sclerosis (ALS, also known as Lou Gehrig's disease), without a waiting period
- People of any age who have End-Stage Renal Disease, which is permanent kidney failure that requires a regular course of dialysis or a kidney transplant

Others who are insured. A very small group of people can get Medicare based on a federally declared environmental health hazard if they have an asbestos-related condition associated with that hazard. Currently this provision applies only to individuals affected by a hazard in Libby, Montana.

Citizenship/residency requirements for Medicare eligibility. To get Part A and/or Part B, you must be a U.S. citizen or legal resident (for at least 5 years in a row) in the U.S. If you live in Puerto Rico, you must actively enroll in Part B.

Medicare handbook. The "Medicare & You" handbook pictured on the slide is mailed to every Medicare household each year in the fall.

CMS Classroom Module 0—Getting Started with Medicare: This self-paced individual learning tool covers Medicare and the decisions people need to make when they select a Medicare option. See Appendix A for descriptions and links to this and other CMS Classroom Modules.

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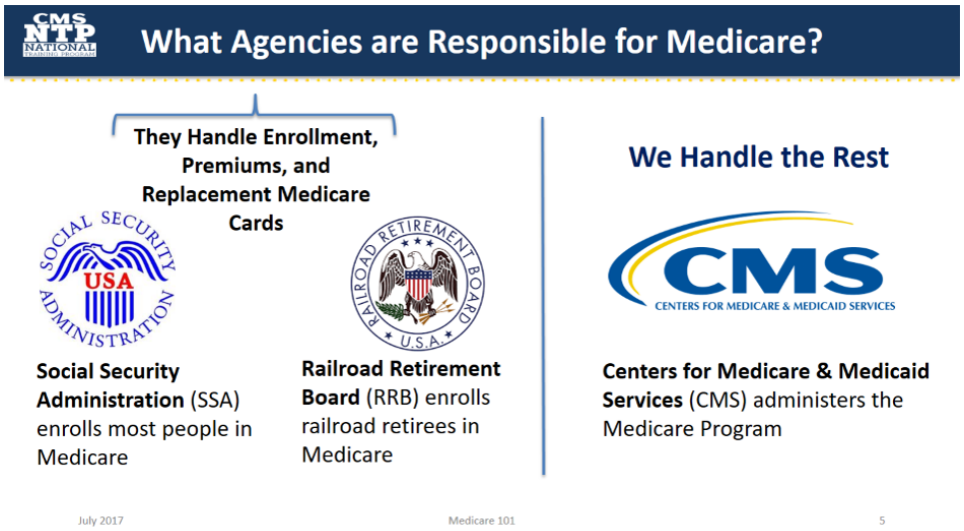

Agencies Responsible for Medicare

Circle the Answer *Where text is underlined, circle the correct word or phrase. See Appendix C for the answer key.*

Enrollment, Premiums, and Replacement Medicare Cards

- The Social Security Administration (SSA) is responsible for enrolling **(all** or **most)** people in Medicare.
- The Railroad Retirement Board (RRB) is responsible for **(enrolling** or **paying claims from)** railroad retirees in Medicare.
- SSA and RRB also collect premiums and determine the amounts of the Part A (if you must pay for it) and Part B premiums. If you retired from federal service, contact the **(Office of Personnel Management** or **SSA)** regarding your premiums.
- SSA and RRB **(handle** or **don't handle)** replacement Medicare cards.

Administration

- Medicare is administered by the Centers for Medicare & Medicaid Services (CMS).

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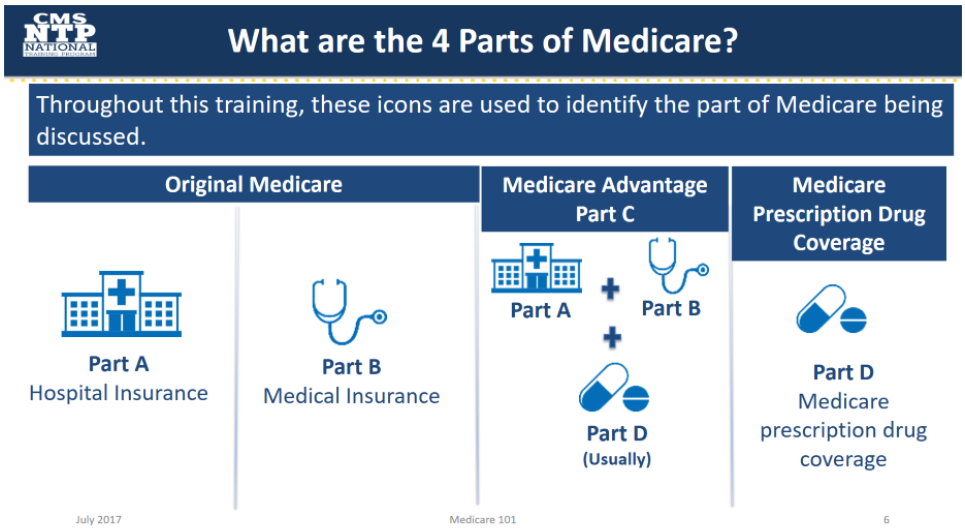
[Slide 6]



The 4 Parts of Medicare

Match Game

Draw a line from each part of Medicare (A, B, C, or D) to its description. See Appendix C for the answer key.

Part A	Hospital + Medical + Prescription Drug Coverage (usually)
Part B	Medicare Prescription Drug Coverage
Part C	Hospital Insurance
Part D	Medical Insurance

Medicare covers many types of services and items, and you have options for how you get your Medicare coverage. Medicare has 4 parts:

> **A +/or B = Original Medicare.** *Part A and/or Part B are also referred to as "Original Medicare."*

- **Part A** (Hospital Insurance)
- **Part B** (Medical Insurance)
- **Part C** (Medicare Advantage (MA)) is another way to get your Medicare benefits. It combines Part A and Part B, and usually Part D (prescription drug coverage). MA Plans are managed by private insurance companies approved by Medicare. These plans must cover medically necessary services.
- **Part D** (Medicare prescription drug coverage) helps pay for outpatient prescription drugs.

Learn more. Appendix D includes a full-page chart with basic information on the 4 parts of Medicare. If you can't review it now, send yourself a reminder to review it later. You might decide to post the chart in your work area as a quick reference.

CMS Classroom Module 1—Understanding Medicare: This self-paced individual learning tool covers Hospital (Part A), medical (Part B), Medicare Advantage (Part C), and prescription drug (Part D) coverage in Medicare. See Appendix A for descriptions and links to this and other CMS Classroom Modules.

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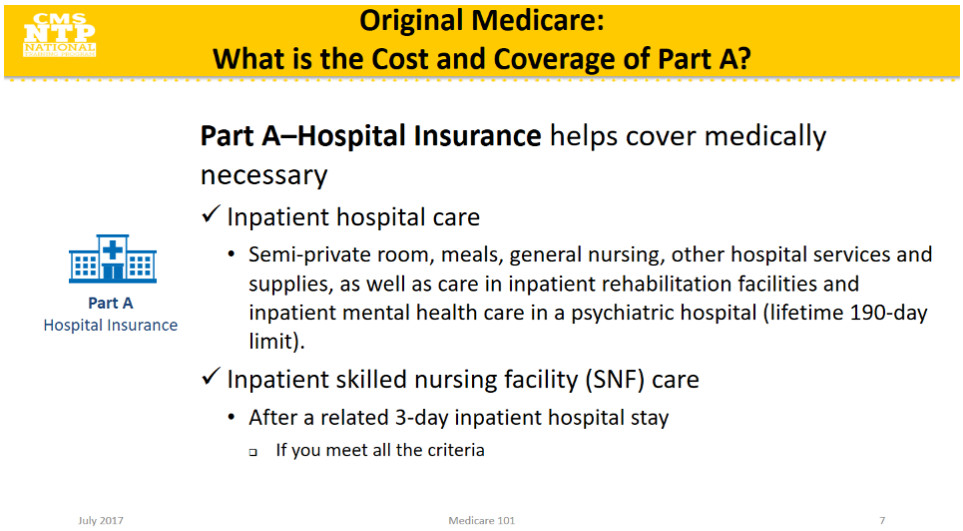
[Slide 7]



Original Medicare: What Does Part A Cover?

Choose from the response options. See Appendix C for the answer key.
Response options: *2, 190*

Here's an overview of what's covered under Part A:

- **Inpatient hospital care**–Semi-private room, meals, general nursing, other hospital services and supplies, as well as care in inpatient rehabilitation facilities and inpatient mental health care in a psychiatric hospital (lifetime _____-day limit).
- **All people with Part A are covered for inpatient hospital care when all of these are true:**
  - A doctor makes an official order which says you need _____ or more midnights of medically necessary care to treat your illness or injury and the hospital formally admits you
  - You need the kind of care that can be given only in a hospital
  - The hospital accepts Medicare
  - The Utilization Review Committee of the hospital approves your stay while you're in a hospital
- **Inpatient skilled nursing facility (SNF) care**–(not custodial or long-term care) if you meet certain criteria. Skilled care involves safe and effective care given by skilled nursing or rehabilitative staff. Skilled nursing and therapy staff includes registered nurses, licensed practical and vocational nurses, physical and occupational therapists, speech-language pathologists, and audiologists.

Who's not covered?

Medicare doesn't pay for your hospital or medical bills if you're not lawfully present in the United States. Also, in most situations, Medicare doesn't pay for your hospital or medical bills if you're incarcerated.

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[Slide 8]

Original Medicare: What Does Part A Cover? (Continued)

Here's more detail about what's covered under Part A:

- **Blood**–In most cases, if you need blood as an inpatient, you won't have to pay or replace it.
- **Certain inpatient health care services in approved religious nonmedical health care institutions (RNHCIs)** –Medicare will only cover the inpatient nonreligious, nonmedical items and services. Examples include room and board, or any items or services that don't require a doctor's order or prescription, like unmedicated wound dressings or use of a simple walker.
- **Home health care**–As described later in this lesson.
- **Hospice care**–As described later in this lesson.

What's not covered?

- Private-duty nursing
- Private room (unless medically necessary)
- Television and phone in your room (if there's a separate charge for these items)
- Personal care items (like razors or slipper socks)

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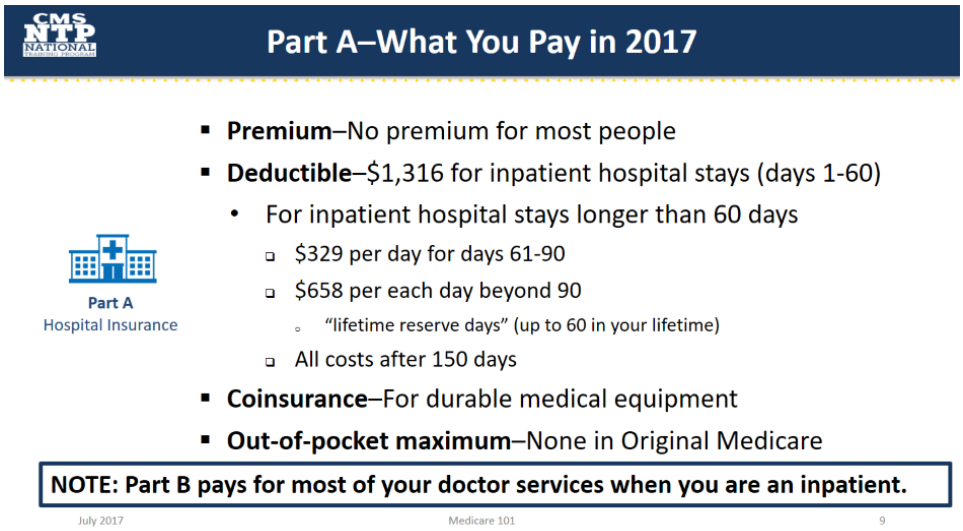
[Slide 9]



Overview of Part A Costs for 2017

Match Game

Draw a line from each description (1-3) to the correct dollar amount (a-c). See Appendix C for the answer key.

1. Part A monthly premium for most people	a. $413
2. Part A deductible for inpatient hospital stay of 60	b. $0
3. Highest Part A monthly premium (for people who paid Medicare taxes for less than 30 quarters and buy Part A) without a late enrollment penalty	c. $1,316

Premium–No premium for most people.

If you buy Part A, you'll pay up to $413 each month in 2017.

- If you paid Medicare taxes for fewer than 30 quarters, the standard Part A premium is $413.
- If you paid Medicare taxes for 30-39 quarters, the standard Part A premium is $227.

In most cases, if you choose to buy Part A, you must also have Medicare Part B (Medical Insurance) and pay monthly premiums for both.

Deductible–$1,316 for inpatient hospital stays (days 1-60)

For inpatient hospital stays longer than 60 days, you will also pay the following:

- $329 per day (days 61-90)
- $658 per each "lifetime reserve day" (day 91 and beyond, for up to 60 days over your lifetime)
- All costs beyond lifetime reserve days (day 150 and beyond)

Coinsurance–For durable medical equipment

Out-of-pocket maximum–None in Original Medicare

Medicare Part B (Medical Insurance) covers most of your doctor services when you're an inpatient. You pay 20% of the Medicare-approved amount for doctor services after paying the Part B deductible.

Cost-Related Words to Know

Premiums–The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Deductibles–The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Copayment–An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage.

Coinsurance–An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

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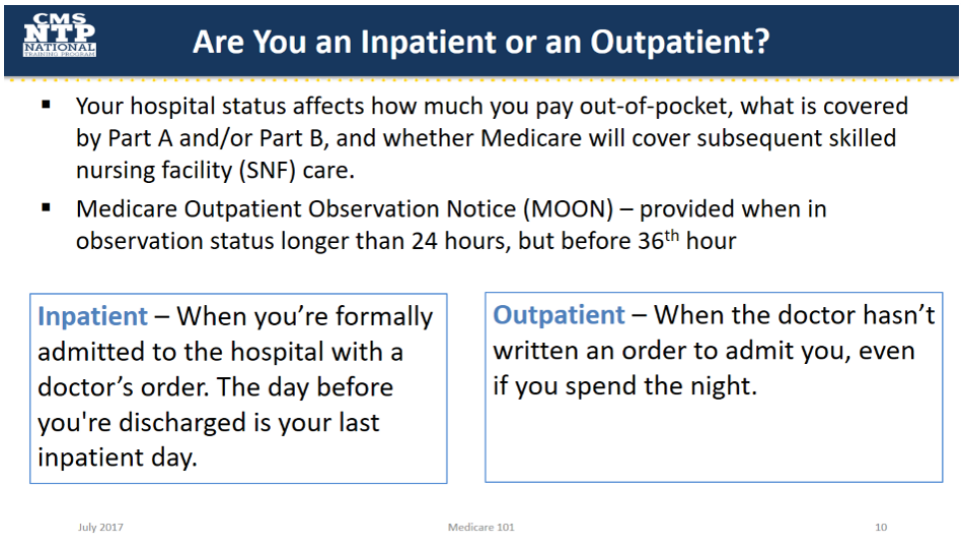
[Slide 10]



Are You an Inpatient or an Outpatient?

Circle the Answer *Where text is underlined, circle the correct word or phrase. See Appendix C for the answer key.*

Why your hospital status matters. Your hospital status (whether the hospital considers you an "inpatient" or "outpatient") affects how much you pay for hospital services (like X-rays, drugs, and lab tests) and may also affect whether Medicare will cover care you get in a skilled nursing facility following your hospital stay.

Inpatient status. You're an inpatient starting when you're formally admitted to a hospital with a doctor's order. The **(day** or **day before)** you're discharged is your last inpatient day.

Inpatient admission. An inpatient admission is generally appropriate when you're expected to need **(2** or **3)** or more midnights of medically necessary hospital care, but your doctor must order such admission and the hospital must formally admit you for you to become an inpatient. If you have a Medicare Advantage Plan (like an HMO or PPO), your costs and coverage may be different. Check with your plan.

Outpatient status. You're an outpatient if you're getting emergency department services, observation services, outpatient surgery, lab tests, X-rays, or any other hospital services, and the doctor **(has** or **hasn't)** written an order to admit you to a hospital as an inpatient. In these cases, you're an outpatient even if you spend the night at the hospital.

Copayments and deductibles. The copayment for a single outpatient hospital service can't be more than the inpatient hospital deductible. However, your total copayment for all outpatient services **(may** or **may not)** be more than the inpatient hospital deductible.

Medicare Outpatient Observation Notice (MOON)

What is the MOON? The MOON (Form CMS 10611-MOON) is a standardized notice to inform people with Medicare (including health plan enrollees) that they are outpatients receiving observation services and aren't inpatients of a hospital or critical access hospital (CAH).

When is a MOON to be provided? The MOON is to be provided if observation is longer than 24 hours, but before the **(36th** or **48th)** hour of observation.

Learn more. For more information, visit CMS.gov/medicare/medicare-general-information/bni/.

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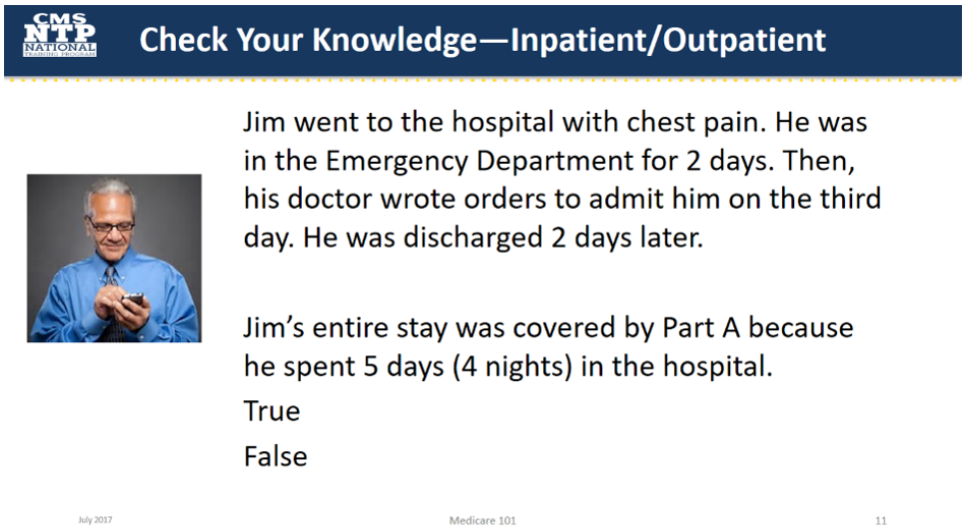
[Slide 11]



Check Your Knowledge—Inpatient/Outpatient (Jim)

True or False

Select True or False for the scenario described below. See Appendix C for the answer key.

Scenario: Jim went to the hospital with chest pain. He was in the Emergency Department for 2 days. Then, his doctor wrote orders to admit him on the third day. He was discharged 2 days later.

Is the following statement true or false? Jim's entire stay was covered by Part A because he spent 5 days (4 nights) in the hospital. **(True** or **False)**

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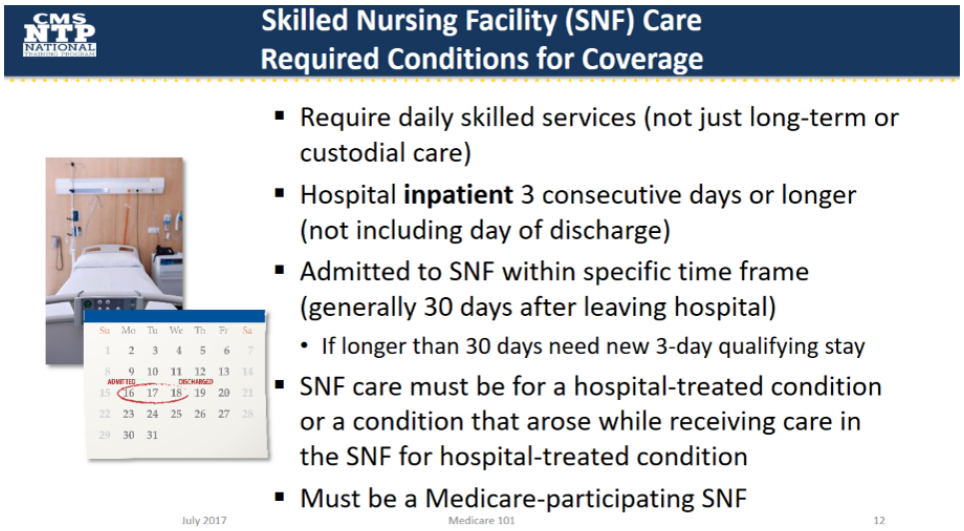
[Slide 12]



Skilled Nursing Facility Care: Required Conditions for Coverage

Circle the Answer

Where text is underlined, circle the correct word or phrase. See Appendix C for the answer key.

Part A will pay for skilled nursing facility (SNF) care if you meet the following conditions:

- **Your doctor (must** or **doesn't need to) certify** that your condition requires daily skilled nursing or skilled rehabilitation services which can only be provided in a SNF.
- **This (does** or **doesn't) include custodial or long-term care.** Medicare doesn't cover custodial care if it's the only kind of care you need. Custodial care is often given in a nursing facility. Generally, skilled care is available only for a short time after a hospitalization. Custodial care may be needed for a much longer period of time.
- **You were an inpatient in a hospital for 3 consecutive days or (less** or **longer)** before you were admitted to a participating SNF. The 3 consecutive calendar day stay requirement can be met by stays totaling 3 consecutive days in one or more hospitals. In determining whether the requirement has been met, the day of admission, but not the day of discharge, is counted as a hospital inpatient day. It's important to note that an overnight stay doesn't guarantee that you're an inpatient. An inpatient hospital stay begins the day you're formally admitted with a doctor's order.

> **Custodial care** is care that helps you with usual daily activities, like getting in and out of bed, eating, bathing, dressing, and using the bathroom. It may also include care that most people do themselves, like using eye drops, oxygen, and taking care of a colostomy or bladder catheters.

- **You were admitted to the SNF within (30** or **60) days after leaving the hospital.** After 30 days, you would need a new 3-day qualifying stay. It wouldn't have to be for the same condition.

- **Your care in the SNF (is** or **is not) for a condition that was treated in the hospital** or arose while receiving care in the SNF for a hospital-treated condition.
- **The facility (must** or **doesn't need to) be a Medicare-participating SNF.**

Learn more. For more information, read "Medicare Coverage of Skilled Nursing Facility Care" at Medicare.gov/Pubs/pdf/10153.pdf.

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[Slide 13]

Skilled Nursing Facility Covered Services

If you qualify, Medicare will cover the following skilled nursing facility (SNF) services:

- Semi-private room (a room you share with one other person)
- Meals
- Skilled nursing care
- Physical, occupational, and speech-language therapy (if needed to meet your health goal)
- Medical social services
- Medications and medical supplies/equipment used in the facility
- Ambulance transportation to the nearest supplier of needed services that aren't available at the SNF when other transportation endangers health
- Dietary counseling

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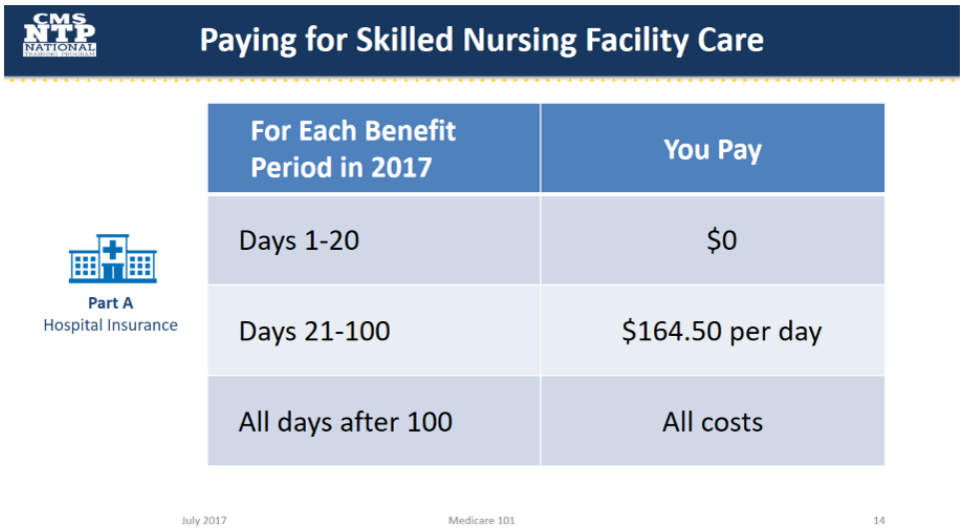
[Slide 14]



Paying for Skilled Nursing Facility Care

Match Game

Draw a line from each question (1–4) to its correct answer (a–d).
See Appendix C for the answer key.

1. How long is Skilled nursing facility (SNF) care covered in full when you meet the requirements for a Medicare-covered stay?
2. Under Original Medicare, in 2017, which days of SNF care are covered for each benefit period except for coinsurance of up to $164.50 per day?
3. When can you qualify for SNF again?
4. When does Medicare Part A no longer cover SNF care?

a. All days after 100
b. Every time you have a new benefit period and meet other criteria
c. For the first 20 days
d. Days 21-100

Days 1-20. SNF care is covered in full for the first 20 days when you meet the requirements for a Medicare-covered stay.

Days 21-100. In 2017, under Original Medicare, days 21–100 of SNF care are covered for each benefit period except for coinsurance of up to $164.50 per day.

All days after 100. After 100 days, Medicare Part A no longer covers SNF care.

New benefit period. You can qualify for SNF care again every time you have a new benefit period and meet the other criteria.

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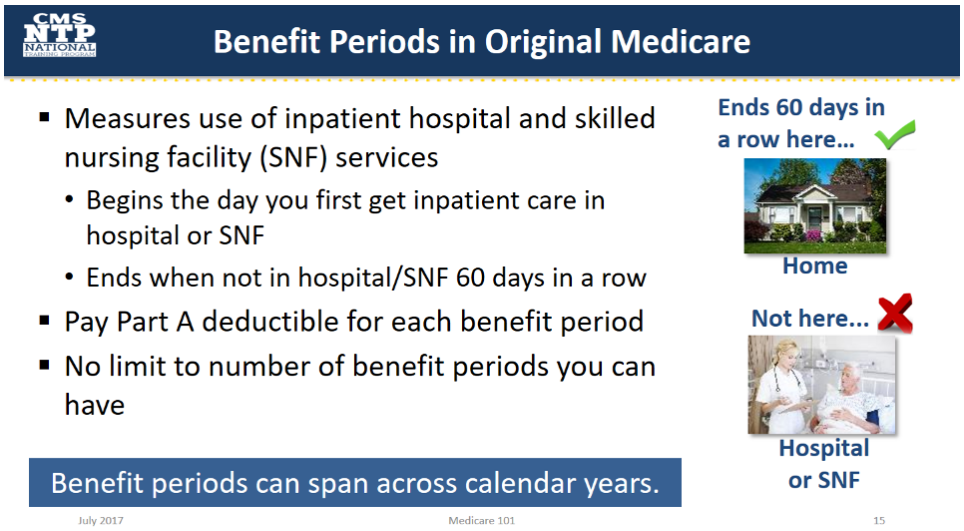
[Slide 15]



Benefit Periods in Original Medicare

Circle the Answer

Where text is underlined, circle the correct word or phrase.
See Appendix C for the answer key.

A benefit period refers to the way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services.

1. A benefit period begins the **(day** or **day after)** you're admitted as an inpatient in a hospital or SNF.
2. The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in a SNF) for **(30** or **60)** days in a row. (The day before you're discharged is your last inpatient day.)
3. If you go into a hospital or a SNF **(before** or **after)** one benefit period has ended, a new benefit period begins.
4. You must pay the **(Part A** or **Part B)** inpatient hospital deductible for each benefit period.
5. There's **(a** or **no)** limit to the number of benefit periods you can have.
6. Benefit periods **(can** or **can't)** span across calendar years.

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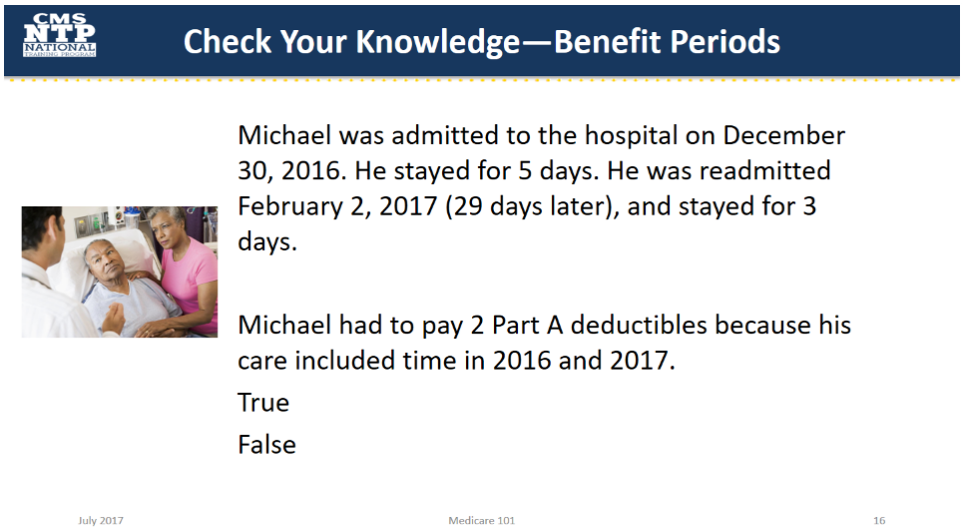
[Slide 16]



Check Your Knowledge—Benefit Periods (Michael)

True or False

Select True or False for the scenario described below. See Appendix C for the answer key.

Scenario: Michael was admitted to the hospital on December 30, 2016. He stayed for 5 days. He was readmitted February 2, 2017 (29 days later), and stayed for 3 days.

Is the following statement true or false? Michael had to pay 2 Part A deductibles because his care included time in 2016 and 2017. **(True** or **False)**

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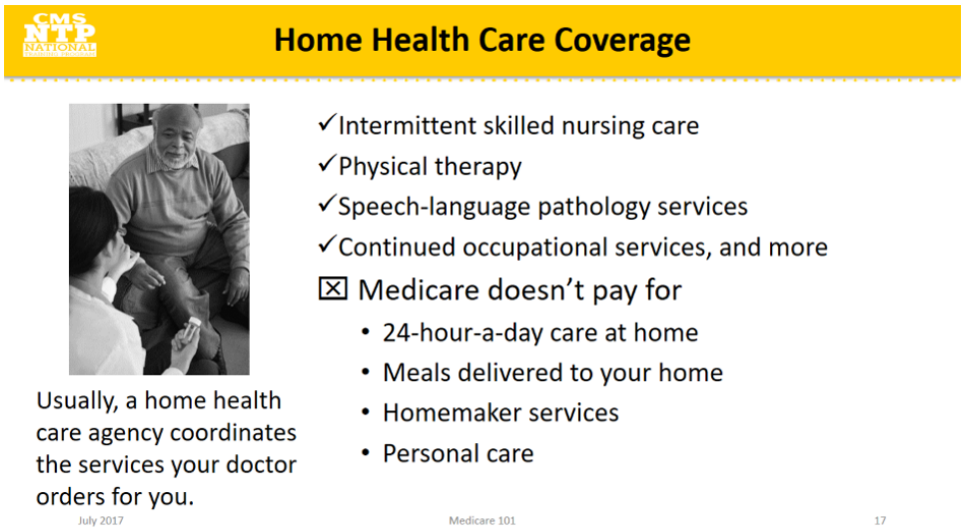
[Slide 17]



Home Health Care Coverage

True or False

Select True or False for each of the following statements. See Appendix C for the answer key.

1. If your doctor orders home health care services for you, the doctor usually coordinates those services. (True or False)
2. Physical therapy is one of the home health care services Medicare covers. (True or False)
3. Home meal delivery is one of the home health care services Medicare covers. **(True** or **False)**

Covered home health services include the following:

- Intermittent skilled nursing care
- Physical therapy
- Speech-language pathology services
- Continued occupational services, and more
- May also include medical social services, part-time or intermittent home health aide services, medical supplies for use at home, durable medical equipment, or injectable osteoporosis drugs

Usually, a home health care agency coordinates the services your doctor orders for you.

Medicare doesn't pay for the following:

- 24-hour-a-day care at home
- Meals delivered to your home
- Homemaker services
- Personal care

Notes

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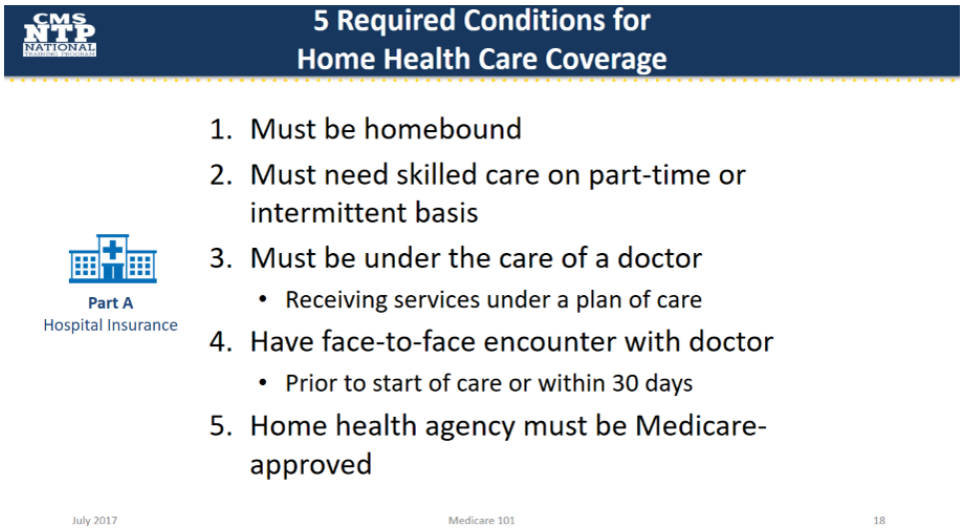
[Slide 18]



5 Required Conditions for Home Health Care Coverage

Circle the Answer

Where text is underlined, circle the correct word or phrase. See Appendix C for the answer key.

To be eligible for home health care services, you must meet all of these conditions:

1. **Homebound status.** You must be homebound. An individual shall be considered "confined to the home" (homebound) if the following 2 criteria are met: (1) The patient must either, because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence, OR (2) have a condition such that leaving his or her home is medically contraindicated. If the patient meets **(both** or **only one)** of the 2 previous conditions, then the patient must ALSO meet these 2 additional requirements: (1) There must exist a normal inability to leave home, AND (2) Leaving home must require a considerable and taxing effort. You may leave home for medical treatment or short, infrequent absences for non-medical reasons, like attending religious services. You can still get home health care if you attend adult day care.
2. **Need for care.** You must need **(skilled** or **unskilled)** care on an intermittent basis, or physical therapy, or speech-language pathology, or have a continuing need for occupational therapy.
3. **Doctor's plan for care.** Your doctor must decide that you need **(skilled** or **unskilled)** care in your home and must make a plan for your care at home.
4. **Documentation of face-to-face encounter with practitioner.** Prior to certifying your eligibility for the Medicare home health benefit, the doctor must document that the doctor or a non-doctor practitioner has had a face-to-face encounter with you. The encounter must be done up to 90 days prior, or within **(7** or **30)** days after the start of care. The law allows the face-to-face encounter to occur via telehealth in rural areas, in an approved originating site. This means medical or other health services given to a patient using a communications system (like a computer, phone, or television), by a practitioner in a location different from the patient's.

5. **Medicare-approved home health agency.** The home health agency caring for you **(must** or **does not have to be)** be approved by Medicare.

Part B also may pay for home health care under certain conditions. For instance, Part B pays for home health care if an inpatient hospital stay doesn't precede the need for home health care, or when the number of Part A–covered home health care visits exceed 100.

Learn more. For more information, read "Medicare and Home Health Care," at http://www.Medicare.gov/Publications/Search/results.asp?PubID=10969&PubLanguage=1&Type=PubID. You can also visit CMS.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html.

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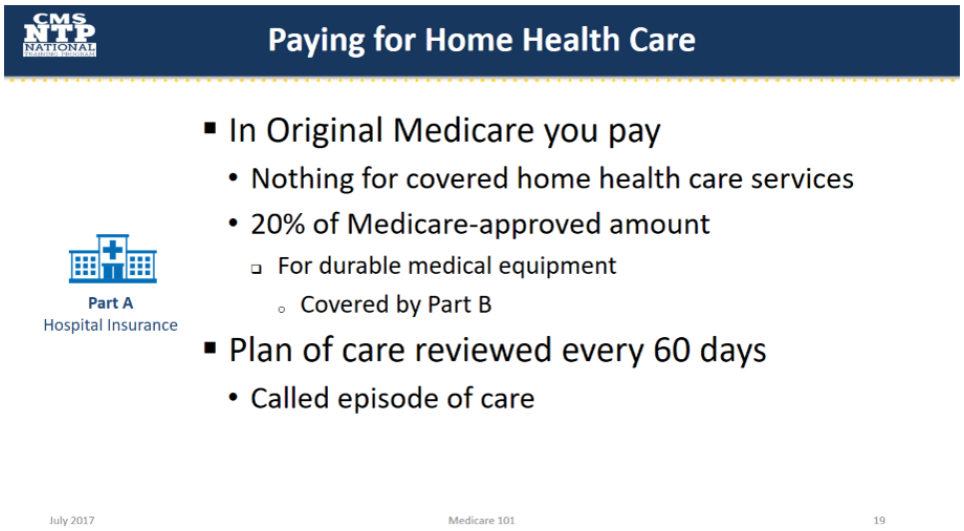
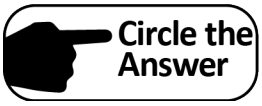
[Slide 19]



Paying for Home Health Care



Where text is underlined, circle the correct word or phrase.
See Appendix C for the answer key.

In Original Medicare, for Part A–covered home health care

- **You pay (a deductible** or **nothing) for covered home health care services provided** by a Medicare-approved home health agency.
- **Durable medical equipment, when ordered by a doctor, is paid separately by (Medicare** or **the patient).** This equipment must meet certain criteria to be covered. Medicare usually pays 80% of the Medicare-approved amount for certain pieces of medical equipment, such as a wheelchair or walker. If your home health agency doesn't supply durable medical equipment directly, the home health agency staff will usually arrange for a home equipment supplier to bring the items you need to your home.
- **Medicare pays your Medicare-certified home health agency one payment for covered services you get during a (60** or **120)-day period.** This period is called an "episode of care." The payment is based on your condition and care needs.

When Part B covers home health care. Part A covers post-institutional home health services furnished during a home health "spell of illness" for up to 100 visits. After you exhaust 100 visits of Part A post-institutional home health services, Part B covers the balance of the home health "spell of illness." The 100-visit limit doesn't apply to you if you're only enrolled in Part A. If you're enrolled only in Part B and qualify for the Medicare home health benefit, then all of your home health services are paid for under Part B. There is no 100-visit limit under Part B.

To find a home health agency in your area: Visit Medicare.gov and use the Home Health Compare tool, or call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

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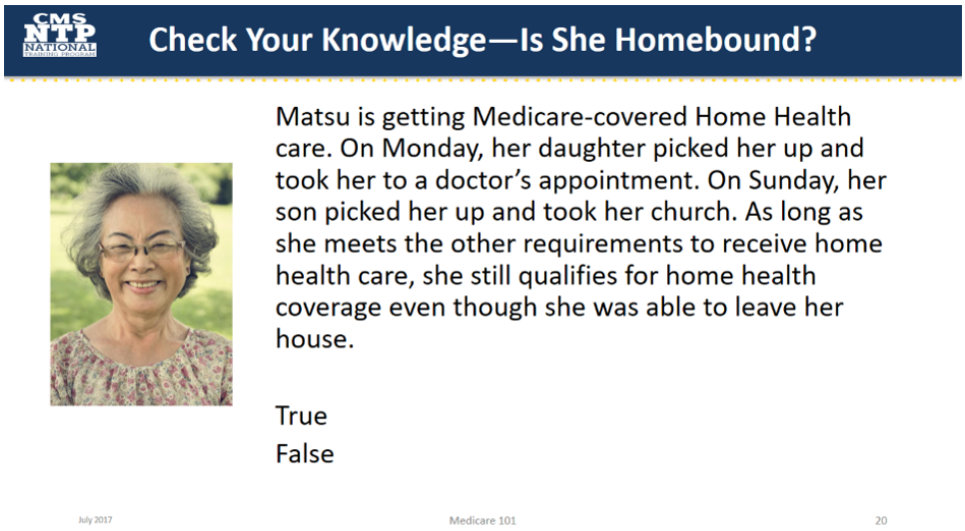

Check Your Knowledge—Is She Homebound? (Matsu)

True or False

Select True or False for the scenario described below. See Appendix C for the answer key.

Scenario: Matsu is getting Medicare-covered home health care. On Monday, her daughter picked her up and took her to a doctor's appointment. On Sunday, her son picked her up and took her church.

Is the following statement true or false? As long as she meets all the other requirements to receive home health care, Matsu still qualifies for home health coverage even though she was able to leave her house. **(True** or **False)**

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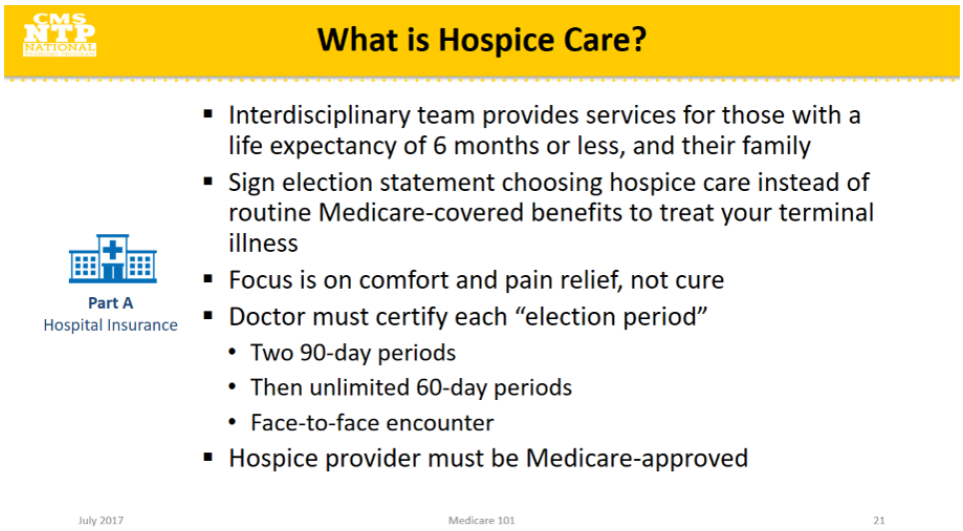

What is Hospice Care?

Select True or False for each of the following statements. See Appendix C for the answer key.

1. The goal of hospice is to cure your illness. **(True** or **False)**
2. If you have a terminal illness, you will automatically receive hospice services instead of routine Medicare-covered benefits. **(True** or **False)**
3. You can get hospice care as long as your doctor certifies that you're terminally ill, and probably have less than 6 months to live. **(True** or **False)**

Part A also covers hospice care, which is a special way of caring for people who are terminally ill and their families. Hospice care is meant to help you make the most of the last months of life by giving you comfort and relief from pain. It involves a team that addresses your medical, physical, social, emotional, and spiritual needs. The goal of hospice is to care for you and your family, not to cure your illness.

How do you choose hospice care? You must sign an election statement choosing hospice care instead of routine Medicare-covered benefits to treat your terminal illness. However, medical services not related to your hospice condition would still be covered by Medicare.

How do you qualify for hospice care? You can get hospice care as long as your doctor certifies that you're terminally ill, and probably have less than 6 months to live if the illness runs its normal course. Care is given in "election periods"—two 90-day periods, followed by unlimited 60-day periods. At the start of each benefit period, your doctor must certify that you're terminally ill for you to continue getting hospice care.

What are some of the other requirements for hospice care? Medicare also requires face-to-face visits. The doctor is required to meet with you within 30 days of hospice recertification, starting before the third election period and each subsequent recertification.

The hospice provider must be Medicare approved.

Learn more. For more information, read "Medicare Hospice Benefits" at https://www.medicare.gov/Pubs/pdf/02154-Medicare-Hospice-Benefits.PDF.

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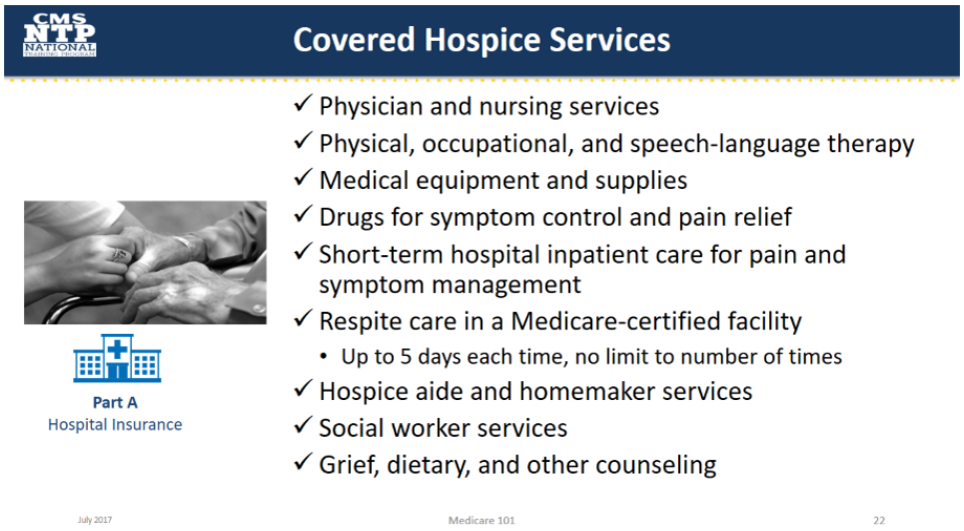

Covered Hospice Services

In addition to the regular Medicare-covered services, such as doctor and nursing care, physical and occupational therapy, and speech language therapy, the hospice benefit also covers the following:

- Medical equipment (such as wheelchairs or walkers)
- Medical supplies (such as bandages and catheters)
- Drugs for symptom control and pain relief
- Short-term care in the hospital, hospice inpatient facility, or skilled nursing facility when needed for pain and symptom management
- Inpatient respite care, which is care given to you by another caregiver, so your usual caregiver can rest. You'll be cared for in a Medicare-approved facility, such as a hospice inpatient facility, hospital, or nursing home. You can stay up to 5 days each time you get respite care, and there's no limit to the number of times you can get respite care. Hospice care is usually given in your home (or a facility you live in). However, Medicare also covers short-term hospital care when needed.
- Hospice aide and homemaker services
- Social worker services
- Other covered services as well as services Medicare usually doesn't cover, like spiritual and grief counseling
- Dietary and other counseling

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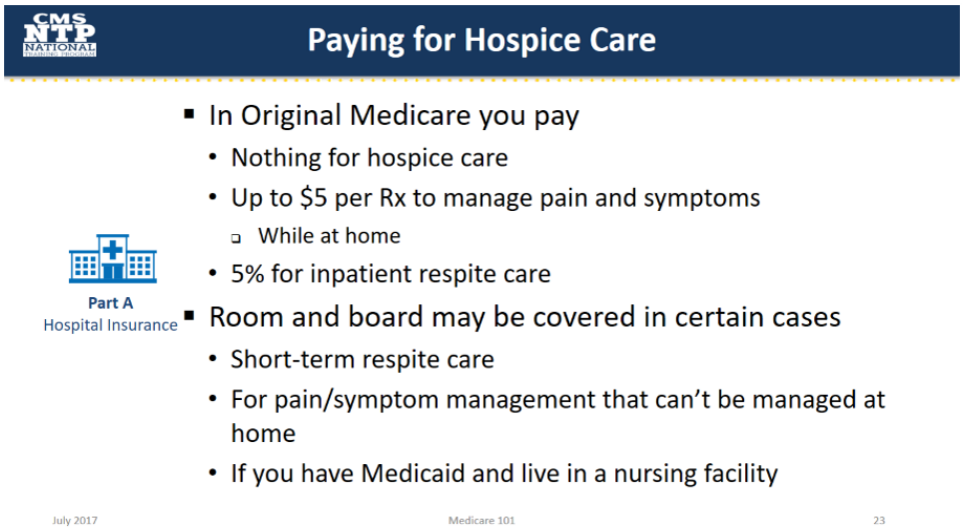
[Slide 23]



Paying for Hospice Care

Circle the Answer Where text is underlined, circle the correct word or phrase. See Appendix C for the answer key.

Copayments. For hospice care in Original Medicare, you pay a copayment of no more than **($5** or **$10)** for each prescription drug and other similar products for pain relief and symptom control while receiving routine or continuous care at home, and **(5%** or **10%)** of the Medicare-approved payment amount for inpatient respite care. For example, if Medicare has approved a charge of $150 per day for inpatient respite care, you'll pay **($5.00** or **$7.50)** per day. The amount you pay for respite care can change each year.

Room and board. Room and board are only payable by Medicare in certain cases. Room and board **(are** or **aren't)** covered during short-term inpatient stays for pain and symptom management, and for respite care. Room and board **(are** or **aren't)** covered if you receive general hospice services while a resident of a nursing home or a hospice's residential facility. However, if you have Medicaid as well as Medicare, and reside in a nursing facility, room and board are covered by Medicaid.

Finding a hospice program. To find a hospice program, call 1-800-MEDICARE (1-800-633-4227), TTY: 1-877-486-2048, or your state hospice organization.

Learn more. For more information, visit the "Medicare Benefit Policy Manual," Chapter 9, Coverage of Hospice Services under Hospital Insurance, at CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf.

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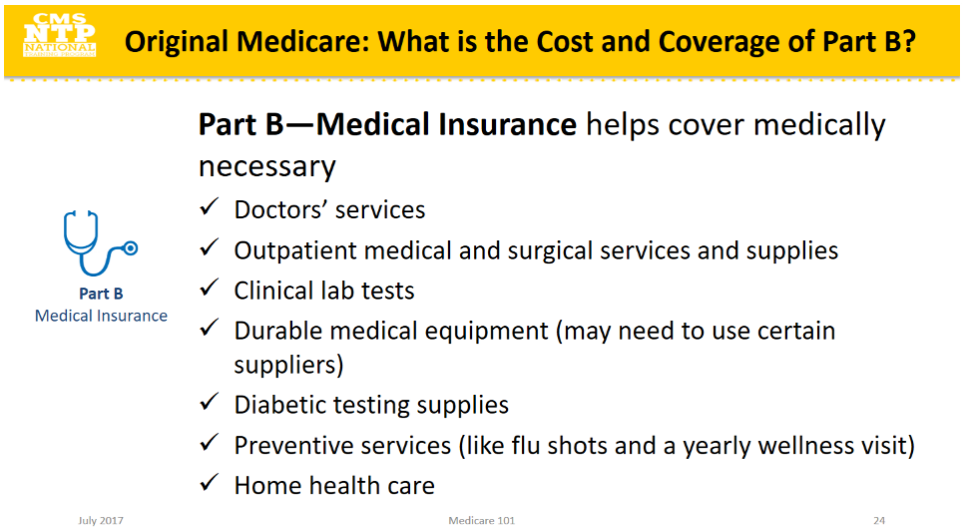

Original Medicare: What Does Part B Cover?

Medicare Part B helps cover medically necessary outpatient services and supplies, including the following:

- **Doctors' services–**Services that are medically necessary.
- **Outpatient medical and surgical services and supplies–**For approved procedures like X-rays or stitches.
- **Clinical laboratory services–**Blood tests, urinalysis, and some screening tests.
- **Durable medical equipment like walkers and wheelchairs–**You may need to use certain suppliers under the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Competitive Bidding Program. Visit Medicare.gov/supplierdirectory/.
- **Diabetic testing supplies–**You may need to use specific suppliers for some types of diabetic testing supplies.
- **Preventive services–**Exams, tests, screenings, and some shots to prevent, find, or manage a medical problem (like flu shots and a yearly wellness visit).
- **Home health services–**You can use your home health benefits under Part A and/or Part B.

Part B pays for home health care in certain situations. Part B pays if an inpatient hospital stay doesn't precede the need for home health care, or when the number of Part A–covered home health care visits exceed 100.

Learn more. For more information, read "Medicare and Home Health Care," at https://www.medicare.gov/Pubs/pdf/10969-Medicare-and-Home-Health-Care.pdf. You can also visit CMS.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html.

CMS Classroom Module 7—Medicare Preventive Services: This self-paced individual learning tool covers Medicare-covered services that help people with Medicare live longer and healthier lives, including why preventive services are important and who is eligible. See Appendix A for descriptions and links to this and other CMS Classroom Modules.

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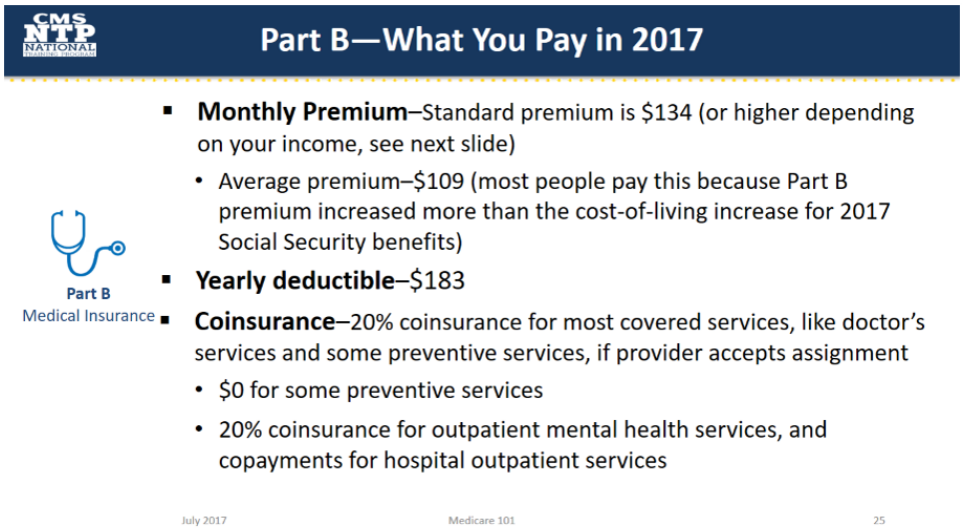
[Slide 25]



Part B—What You Pay in 2017

Match Game

Draw a line from the dollar amount on the left (1-4) to its description on the right (a-d). See Appendix C for the answer key.

1. $0	a. Standard Part B premium for 2017
2. $109	b. Monthly Part B premium for most people in 2017
3. $134 or more	c. Yearly deductible for Part B
4. $183	d. Coinsurance for some preventive services

Monthly premium. You pay a premium for Part B each month. The standard Part B premium amount in 2017 is $134 (or higher depending on your income, as discussed on the next page). However, most people who get Social Security benefits will pay less than this amount. This is because the Part B premium increased more than the cost-of-living increase for 2017 Social Security benefits. If you pay your Part B premium through your monthly Social Security benefit, you'll pay less ($109 on average). Social Security will tell you the exact amount you will pay for Part B.

Yearly deductible. There is a yearly deductible of $183 that you pay before Part B begins to pay.

Coinsurance. You pay coinsurance of 20% for most covered services, like doctor's services and some preventive services, if the provider accepts assignment. You pay $0 for some preventive services, and you pay 20% coinsurance for outpatient mental health services, and copayments for hospital outpatient services.

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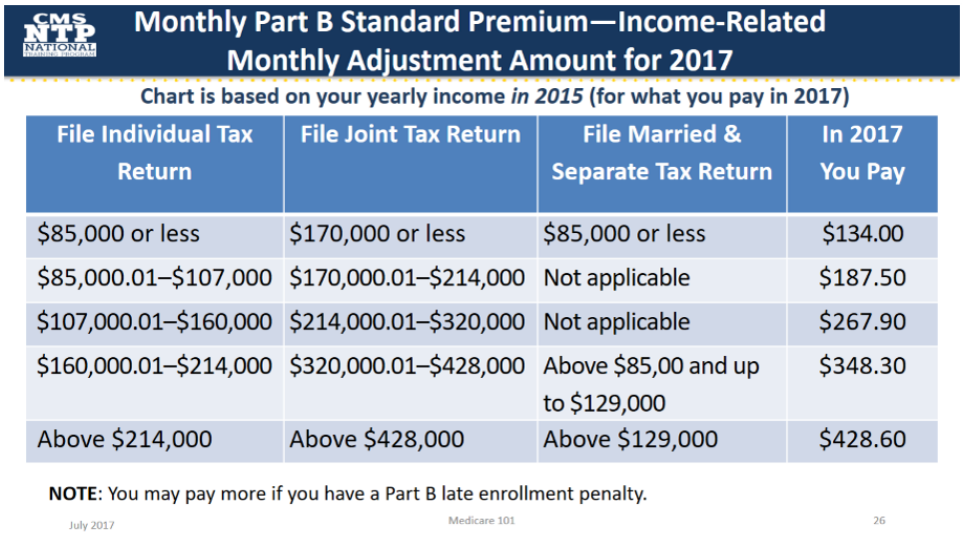
[Slide 26]



Monthly Part B Standard Premium—Income-Related Monthly Adjustment Amount for 2017

Since 2007, people with Medicare with higher incomes have paid higher Medicare Part B monthly premiums. These income-related monthly premium rates affect roughly 5% of people with Medicare. The total Medicare Part B premiums for people with higher income for 2017 are shown in the table above.

Income-related premiums Part B premiums. For those whose income is

- $85,000 or less, and file an individual tax return, file a joint tax return with a yearly income of $170,000 or less, or file married with separate tax returns, the Part B premium is $134.00 per month
- $85,000.01–$107,000, and file an individual tax return, file a joint tax return with a yearly income above $170,000 up to $214,000, or file married with separate tax returns, the Part B premium is $187.50 per month
- $107,000.01–$160,000, and file an individual tax return, file a joint tax return with a yearly income of above $214,000 up to $320,000, or file married with a separate tax return, the Part B premium is $267.90 per month
- $160,000.01–$214,000, and file an individual tax return, file a joint tax return with an income above $320,000 up to $428,000, or file married with separate tax returns with an income above $85,000 and up to $129,000, the Part B premium is $348.30 per month
- Above $214,000, and file an individual tax return, file a joint tax return with an income above $428,000, or file married and file separate tax return with an income above $129,000, the Part B premium is $428.60 per month

Who to call if you think your Part B premium is too high. If you have to pay a higher amount for your Part B premium and you disagree (for example, if your income goes down), call Social Security at 1-800-772-1213. TTY: 1-800-325-0778.

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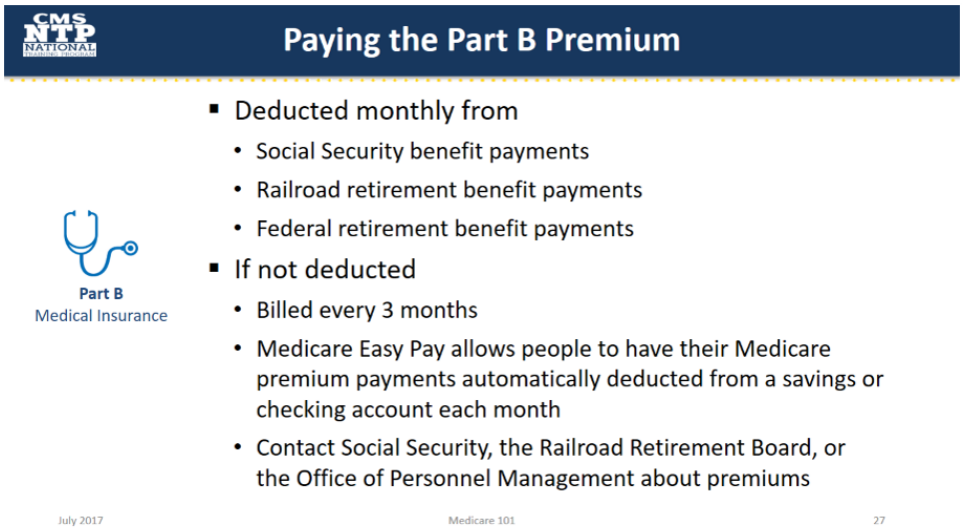
[Slide 27]



Paying the Part B Premium

True or False

Select True or False for each of the following statements. See Appendix C for the answer key.

1. Retired federal employees should call Social Security for information about Part B premiums. **(True** or **False)**

7. Medicare sends monthly bills to people whose retirement payments aren't enough to cover the monthly Part B premium. **(True** or **False)**

When it's deducted from benefit payments. The Part B premium is deducted from monthly Social Security, Railroad Retirement, or federal retirement benefit payments.

When it's billed to the individual. If you don't get a retirement payment or your payment isn't enough to cover the premium, you'll get a bill from Medicare every 3 months for your Part B premium. The bill can be paid by credit card, check, or money order.

Who to call. For information about Medicare Part B premiums, call Social Security, the Railroad Retirement Board, or the Office of Personnel Management for retired federal employees.

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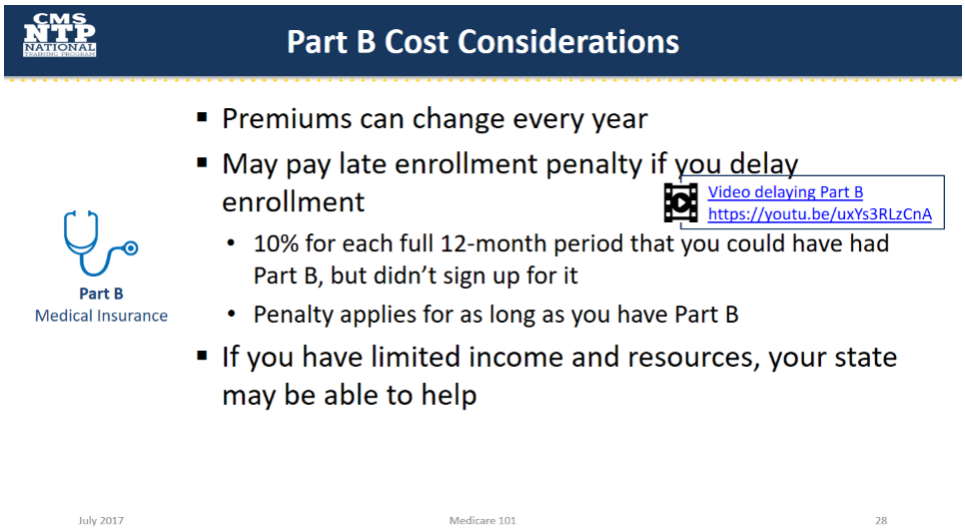
[Slide 28]



Part B Cost Considerations

Circle the Answer *Where text is underlined, circle the correct word or phrase. See Appendix C for the answer key.*

There are several Part B cost considerations, including the following:

- **Premiums.** Premiums **(can** or **can't)** change every year.
- **Penalties for late enrollment.** In most cases, if you don't sign up for Part B when you're first eligible, you'll have to pay a late enrollment penalty. You'll have to pay this penalty for **(12 months** or **as long as you have Part B)**. Your monthly premium for Part B may go up 10% for each full 12-month period that you could have had Part B, but didn't sign up for it. Also, you may have to wait until the General Enrollment Period (from January 1 to March 31) to enroll in Part B. Coverage will start **(April 1** or **July 1)** of that year.
- If you meet certain conditions that allow you to sign up for Part B during a Special Enrollment Period, you usually won't pay a late enrollment penalty.
- **Medicare Savings Programs.** If you have limited income and resources, your state may help you pay for Medicare. See the next page for information about Medicare Savings Programs.

Learn more. For more information, visit Medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html.

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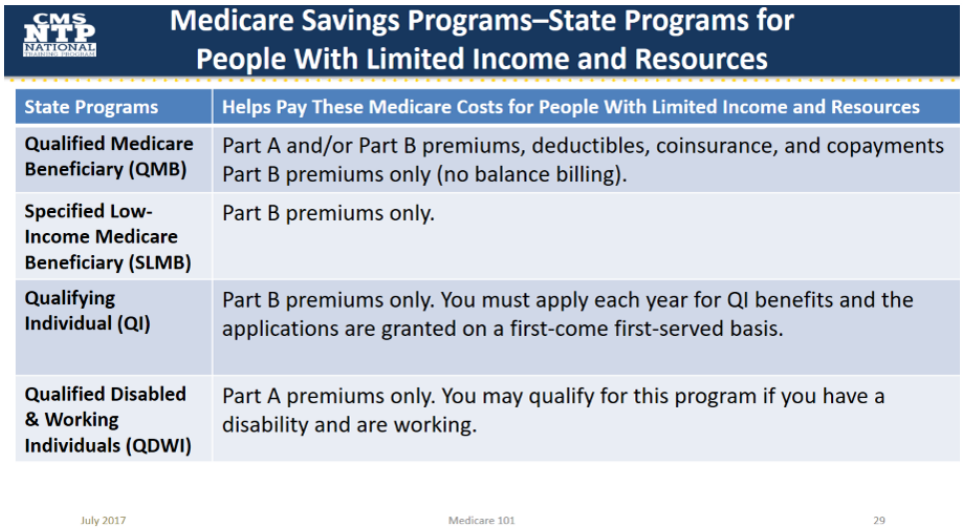

Medicare Savings Programs

States have other programs that pay Medicare premiums and, in some cases, may also pay Medicare deductibles and coinsurance for people with limited income and resources. These programs frequently have higher income and resource guidelines than full Medicaid. These programs are collectively called Medicare Savings Programs, and include the following:

- **Qualified Medicare Beneficiary (QMB) Program**–Helps pay for Part A and/or Part B premiums, deductibles, coinsurance, and copayments. (Federal law bars Medicare and Medicare Advantage providers from balance billing a QMB beneficiary under any circumstances—Medicare cost-sharing, including deductibles, coinsurance, and copayments.)
- **Specified Low-Income Medicare Beneficiary (SLMB) Program**–Helps pay Part B premiums only.
- **Qualifying Individual (QI) Program**–Helps pay Part B premiums only. You must apply each year for QI benefits and the applications are granted on a first-come, first-served basis.
- **Qualified Disabled and Working Individuals (QDWI) Program**–Helps pay Part A premiums only. You may qualify for this program if you have a disability and are working. Eligibility for these programs is determined by income and resource levels. The income amounts are updated annually with the federal poverty level.

State Health Insurance Assistance Programs. Many states figure your income and resources differently, so you may qualify in your state even if your income or resources are higher than the amounts listed above. If you have income from working, you may qualify for benefits even if your income is higher than the limits above. Additionally, some states offer their own programs to help people with Medicare pay the out-of-pocket costs of health care, including State Pharmacy Assistance Programs (SPAPs).

Contact your State Health Insurance Assistance Program (SHIP) to find out which programs may be available to you. To find the contact information for your local SHIP, visit shiptacenter.org.

Learn more. For annual updates, visit Medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html. For more information, visit "Getting Help with your Medicare Costs" at Medicare.gov/Pubs/pdf/10126-Getting-Help-With-Your-Medicare-Costs.pdf.

CMS Classroom Module 12—Medicaid & the Children's Health Insurance Program: This self-paced individual learning tool covers information for people with limited income and resources, including Medicaid, Medicare Savings programs, the Children's Health Insurance Program, and coverage in the U.S. territories. See Appendix A for descriptions and links to this and other CMS Classroom Modules.

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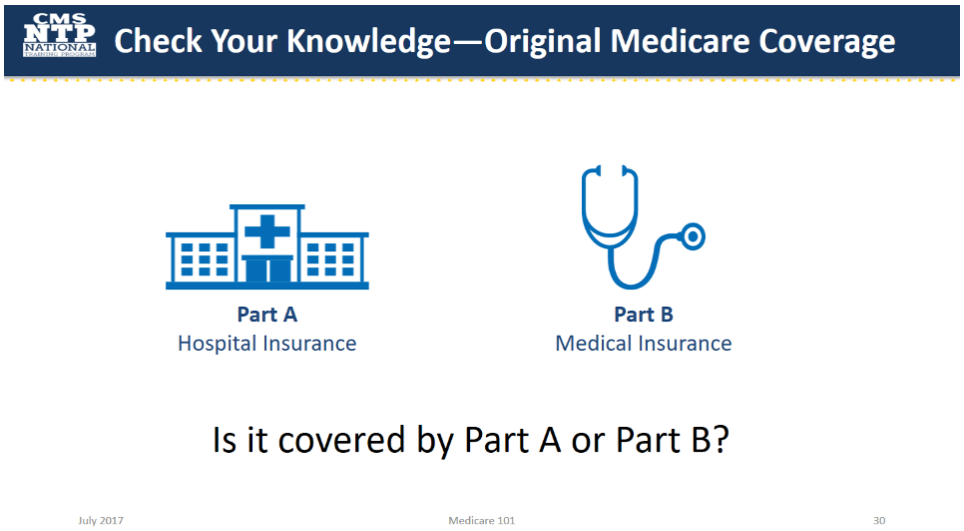

Check Your Knowledge—Original Medicare Coverage

In the activities that follow, identify whether an item or service is covered under Medicare Part A or Part B.

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[Slide 31]

Check Your Knowledge #1–Part A or Part B?

Fill in the Blank

Read the statement below and write in Part A or Part B.
See Appendix C for the answer key.

Medicare Part _____ covers medically necessary doctor's care.

Notes

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[Slide 32]

Check Your Knowledge #2–Part A or Part B?

Fill in the Blank

Read the statement below and write in Part A or Part B.
See Appendix C for the answer key.

Part _____ covers medically necessary inpatient hospital care.

Notes

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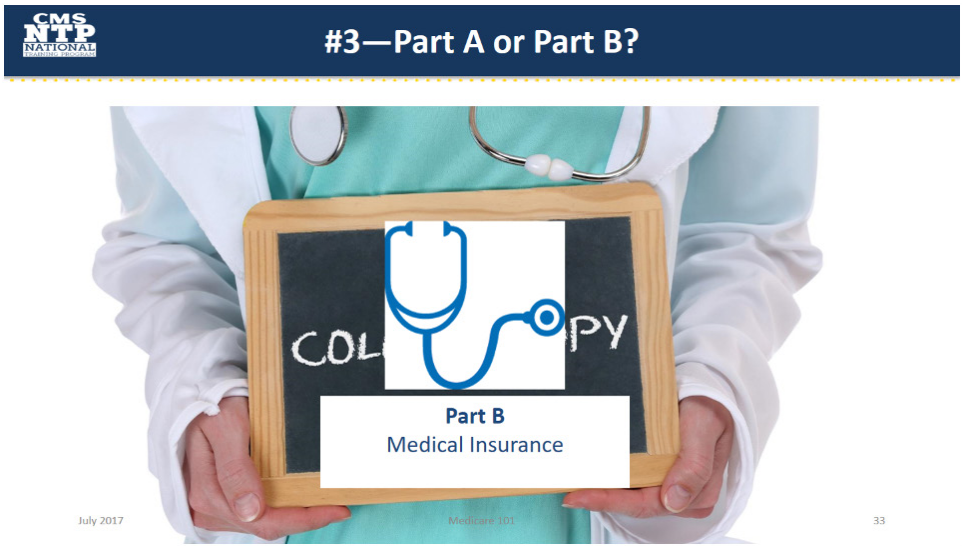
[Slide 33]



Check Your Knowledge #3–Part A or Part B?

Fill in the Blank

Read the statement below and write in Part A or Part B.
See Appendix C for the answer key.

Part _____ covers many preventive services, including colonoscopies.

Notes

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[Slide 34]

Check Your Knowledge #4–Part A or Part B?

Circle the Answer

Where text is underlined, circle the correct word or phrase.
See Appendix C for the answer key.

Acupuncture **(is** or **isn't)** covered by Medicare.

Medicare doesn't cover everything. For instance, Original Medicare doesn't cover routine dental services, hearing aids, or cosmetic surgery.

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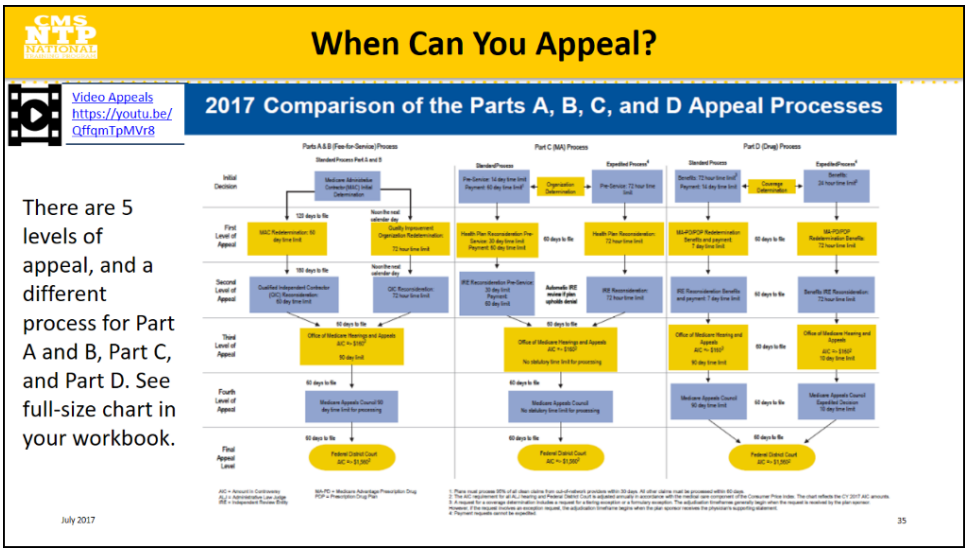
[Slide 35]



Original Medicare Appeals Process

Have you ever gotten a statement from Medicare or your health plan and something wasn't covered but you thought it should have been? Or, maybe Medicare or your plan didn't pay the amount you thought it should've? If so, you may be able to file an appeal.

What is an appeal? An appeal is the action you can take if you disagree with the coverage or payment decision that's made by Medicare.

When do you have the right to appeal? No matter how you get your Medicare coverage, you always have the right to appeal. You have the right to appeal if Medicare or your plan denies any of these things:

- A request for a health care service, supply, item, or prescription drug that you think you should be able to get, or
- A request for payment of a health care service, supply, item or prescription drug that you already got

You can also appeal or request to change the amount that you must pay for a health care service, supply, item, or prescription drug. You can appeal if Medicare or your plan stops providing or paying for all or part of a health care service, supply, item, or prescription drug that you think you still need.

How do you appeal? There is a process when you want to file an appeal, and it has 5 levels. At each level in the process, you'll get a decision. If you disagree with a decision made at any level in the process, you can generally go to the next level by following the instructions you get in the decision letter.

Learn more. For more information, see the "2017 Comparison of the Parts A, B, C, and D Appeal Processes" in Appendix D.

CMS Classroom Module 2—Medicare Rights and Protections: This self-paced individual learning tool covers beneficiary rights. See Appendix A for descriptions and links to this and other CMS Classroom Modules.

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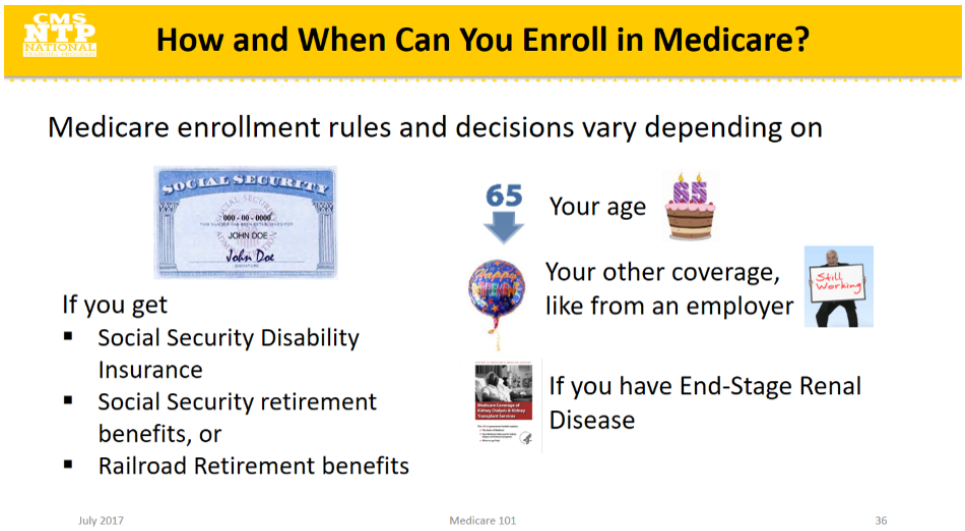
[Slide 36]



Medicare Enrollment

True or False

Select True or False for each of the following statements. See Appendix C for the answer key.

1. Medicare enrollment rules and decisions vary depending on your age. **(True** or **False)**
2. Medicare enrollment rules and decisions vary based on your gender. **(True** or **False)**
8. If you receive Social Security or Railroad Retirement benefits, this may impact Medicare enrollment rules and decisions. **(True** or **False)**

Medicare enrollment rules and decisions vary by your age, other coverage (like from an employer), whether you have End-Stage Renal Disease, and whether you're receiving Social Security or Railroad Retirement benefits.

Notes

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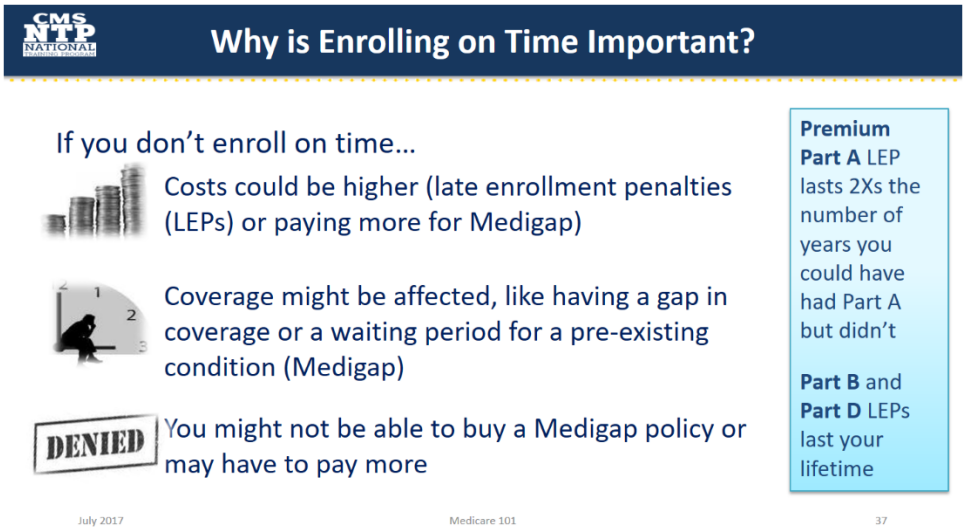
[Slide 37]



Why Is Enrolling on Time Important?

Circle the Answer

Where text is underlined, circle the correct word or phrase.
See Appendix C for the answer key.

If you don't enroll on time

- You may pay **(more** or **less)** for coverage (late enrollment penalties for premium Part A, Part B, and Part D). The Part B and Part D penalties can last as long as you have Part B or Part D. If you aren't eligible for premium-free Part A, and you don't buy it when you're first eligible, your monthly premium may go up **(5%** or **10%)**. You'll have to pay the higher premium for twice the number of **(years** or **months)** you could have had Part A, but didn't sign up.
- You may have a gap in coverage.
- You might not be able to buy a Medigap policy, have to pay more, or have a delay in coverage for a pre-existing condition.

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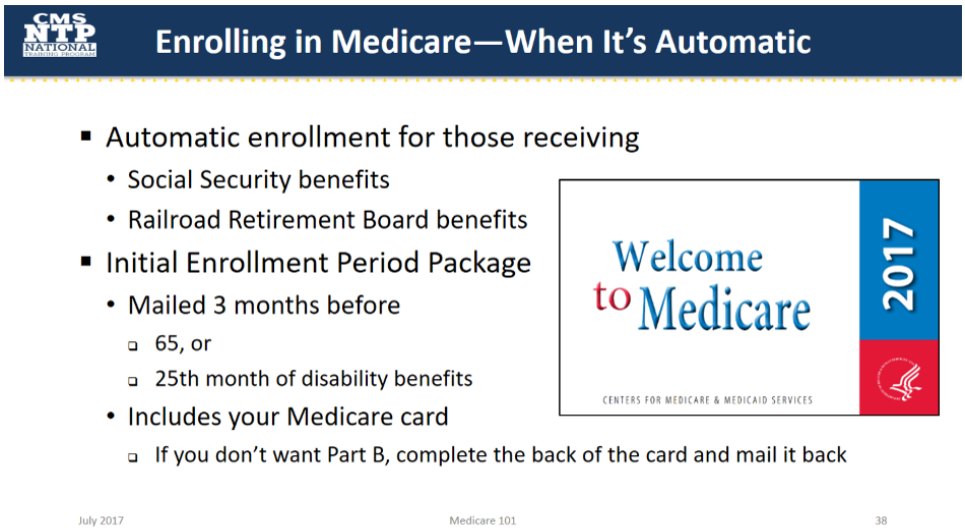
[Slide 38]



Enrolling in Medicare—When It's Automatic

If you're already getting Social Security or Railroad Retirement Board (RRB) benefits (for example, getting early retirement at least 4 months before you turn 65), you'll automatically be enrolled in Medicare Part A and Part B without an additional application. You'll get your Initial Enrollment Period Package, which includes your Medicare card and other information, about 3 months before you turn 65 (coverage begins the first day of the month you turn 65), or 3 months before your 25th month of disability benefits (coverage begins your 25th month of disability benefits).

If you don't want Part B, fill out the back of the Medicare card and mail it back.

If you're not getting retirement benefits from Social Security or the RRB, you must sign up to get Medicare. We'll talk about the periods when you can enroll later.

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[Slide 39]

You Must Take Action to Enroll in Medicare When It's Not Automatic

Circle the Answer

Where text is underlined, circle the correct number.
See Appendix C for the answer key.

When to sign up. If you aren't getting Social Security or Railroad Retirement Board (RRB) benefits at least **(4 or 6)** months before you turn **(50 or 65)** (for instance, because you're still working), you'll need to sign up for Part A (even if you're eligible to get Part A premium-free) and Part B. You should contact Social Security to apply for Medicare **(2 or 3)** months before you turn 65. If you worked for a railroad, contact the RRB to sign up. You don't have to be retired to get Medicare.

Age at which full Social Security benefits are available. For people born in 1938 or later, their Social Security benefit may be affected by a provision that raises the age at which full Social Security benefits are payable. If you were born from 1943 to 1960, the age at which full retirement benefits are payable increases gradually to age **(67 or 70).** You can calculate your age for collecting full Social Security retirement benefits at ssa.gov/retirement/ageincrease.htm.

Age at which partial Social Security benefits are available. Those who sign up for Social Security early get partial retirement benefits. The earliest a person can start receiving reduced Social Security retirement benefits remains **(60 or 62)**. By 2025, full retirement age will be **(65 or 67)** for everyone.

Where to enroll. You can enroll online at socialsecurity.gov, or call 1-800-722-1213, TTY: 1-800-325-0778, or make an appointment at your local Social Security office. To find your local office, visit secure.ssa.gov/ICON/main.jsp.

Learn more. For more information, visit socialsecurity.gov/pubs/EN-05-10035.pdf.

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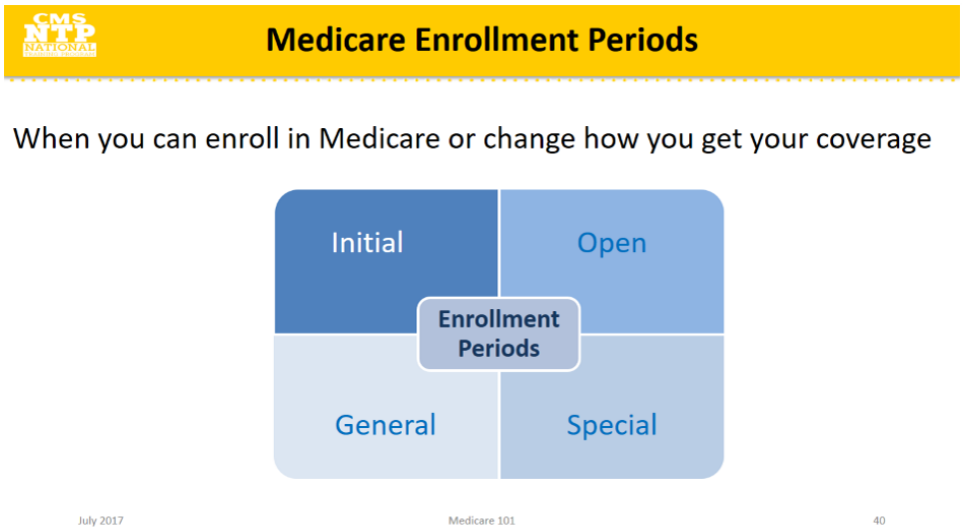

Medicare Enrollment Periods

There are different times when you can enroll in Medicare, or change how you get your coverage:

- Initial Enrollment Period
- Open Enrollment Period
- General Enrollment Period
- Special Enrollment Period

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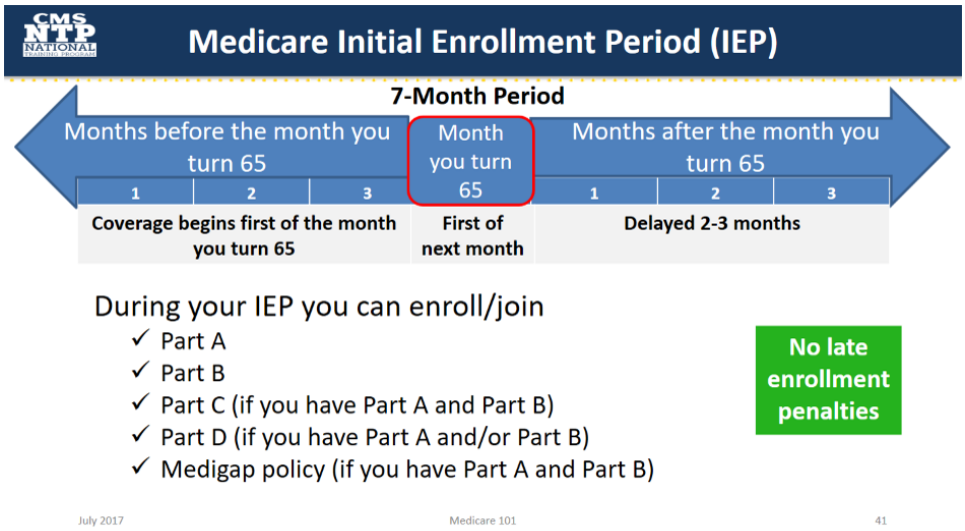
[Slide 41]



Medicare Initial Enrollment Period (IEP)

Match Game

Draw a line from each example (1-3) to its description (a-c) to indicate when your coverage would start. See Appendix C for the answer key.

1. You enroll the month you turn 65.	a. Coverage begins 2 to 3 months after you turn 65.
2. You enroll during the 3 months after you turn 65.	b. Coverage begins the first day of the month you turn 65.
3. You enroll during the 3 months before the month you turn 65.	c. Coverage begins the first day of the next month.

Your first opportunity to enroll in Medicare is during your **Initial Enrollment Period (IEP)**, which lasts 7 months. Your coverage starts based on when you enroll.

- **If you enroll during the first 3 months of your IEP** (the 3 months before the month you turn 65), your coverage will begin the first day of the month you turn 65.
- **If you enroll the month you turn 65,** your coverage will begin the first day of the next month.
- **If you enroll in the last 3 months of your IEP** (the 3 months after you turn 65), your coverage will begin 2 to 3 months after you turn 65.

If you don't enroll in Part B (or premium Part A) during your IEP, you may have to pay a penalty. For Part B, it's a lifetime penalty.

Enrollment in Part A. If you're eligible for premium-free Part A, you can enroll in Part A once your IEP begins (3 months before you turn 65) and any month afterward. If you're not eligible for premium-free Part A, you can only enroll in Part A during your IEP or during the limited Part B enrollment periods.

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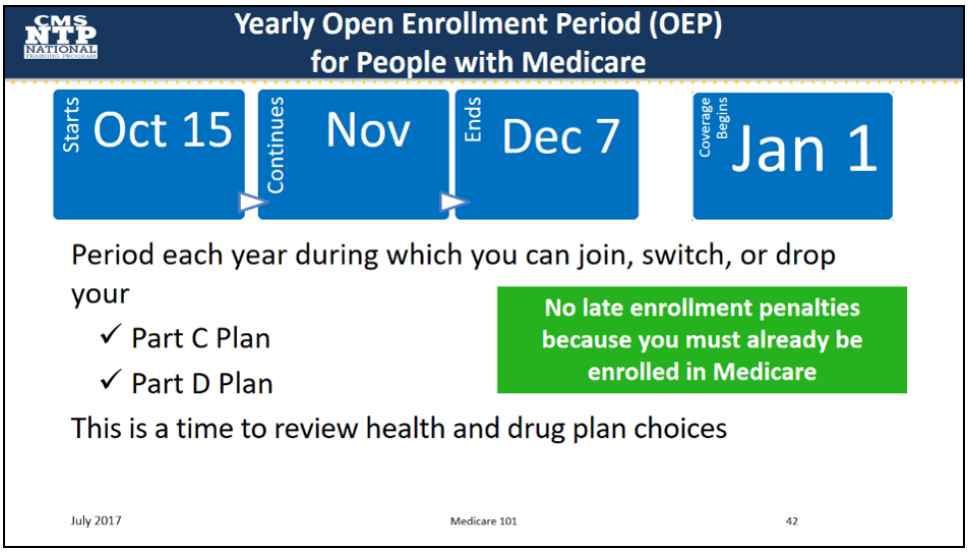
[Slide 42]



Yearly Open Enrollment Period (OEP) for People with Medicare

Purpose for OEP. If you already have Medicare, the yearly Open Enrollment Period (OEP) allows you the opportunity to review your choices and pick the Medicare health and drug plan that works best for you.

Enrollment starts on October 15. Open Enrollment starts on October 15 and ends December 7. This gives you a full 7 weeks to compare and make decisions.

Coverage starts on January 1. The 7-week enrollment period helps ensure that you'll have essential plan materials and membership cards in hand on January 1, when your new coverage starts.

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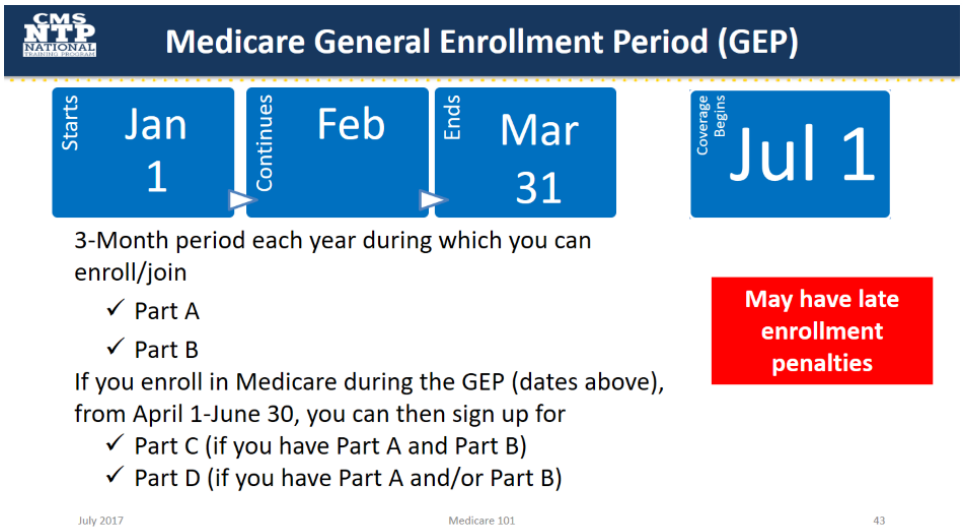
[Slide 43]



Medicare General Enrollment Period (GEP)

Purpose for GEP. If you didn't sign up for Part B (or premium Part A) during your **Initial Enrollment Period** (IEP), you can enroll during the (GEP). For most people who don't enroll during their IEP, this is their only chance to enroll.

Enrollment starts on January 1. The GEP occurs each year. It begins January 1 and ends March 31.

Coverage starts on July 1. If you enroll in the GEP, your coverage will start on July 1. This is required by law.

Penalties for late enrollment (Part B). If more than 12 months passed since you turned 65, you'll likely have to pay a lifetime penalty that is added to your monthly Part B premium. In most cases, you'll have to pay this penalty for as long as you have Part B.

Penalties for late enrollment (Part A). If you aren't eligible for premium-free Part A, and you don't buy it when you're first eligible, your monthly premium may go up 10%. You'll have to pay the higher premium for twice the number of years you could've had Part A, but didn't sign up. This means your monthly premiums will be higher than if you signed up during your IEP. The longer you go without the coverage, the higher the penalty.

If you enroll in Medicare during a GEP (Part A/Part B), you can enroll in a Part C plan (if you have Part A and Part B), or a Part D plan (if you have Part A and/or Part B). The period in which you can join a Part C or Part D plan is from April 1-June 30.

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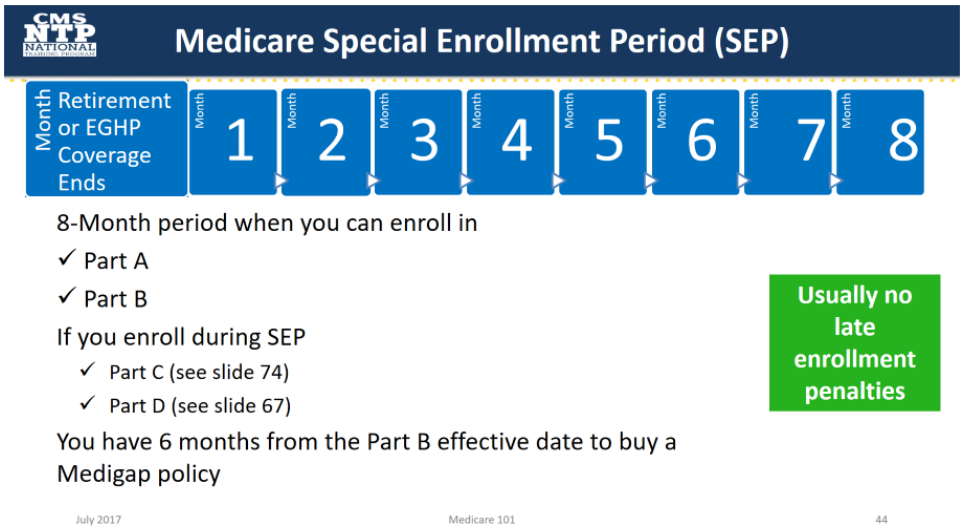
[Slide 44]



Medicare Special Enrollment Period (SEP)

Purpose for SEP. If you or your spouse are still working, and you didn't sign up for Part B (or premium Part A) during your Initial Enrollment Period (IEP), you may be able to enroll during the **SEP**. The SEP allows you to enroll after your IEP and not wait for the General Enrollment Period (GEP). If eligible, you won't have to pay a penalty, but this SEP is limited.

Who's eligible to enroll during an SEP. To be eligible, you must have large group health plan coverage based on active, current employment for all the months you were eligible to enroll in Part B, but didn't. If you're 65 or older, you must get this employer-sponsored coverage based on your or your spouse's current employment. If you have Medicare based on disability, you can also have employer-sponsored coverage based on a member's current employment. It's important to note that COBRA,* retiree coverage, long-term workers' compensation, or Veterans Affairs coverage isn't considered active, current employment.

When the SEP starts (Part A and/or B). You have an 8-month SEP to sign up for Part A and/or Part B that starts at one of these times (whichever happens first):

- The month after the employment ends
- The month after group health plan insurance based on current employment ends

Consequences of late enrollment. If you don't enroll within the 8 months, you'll have to wait until the next GEP to enroll, you'll have a gap in your coverage, and you may have to pay a penalty.

Medigap Open Enrollment Period (OEP). If you delay Part B and get it during your SEP, you start your Medigap OEP. It lasts 6 months.

*COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) is a federal law that may let you keep your employer group health plan coverage for a limited time after your employment ends or after you would otherwise lose coverage. Additional information about COBRA is available at

https://www.medicare.gov/supplement-other-insurance/how-medicare-works-with-other-insurance/who-pays-first/cobra-7-facts.html.

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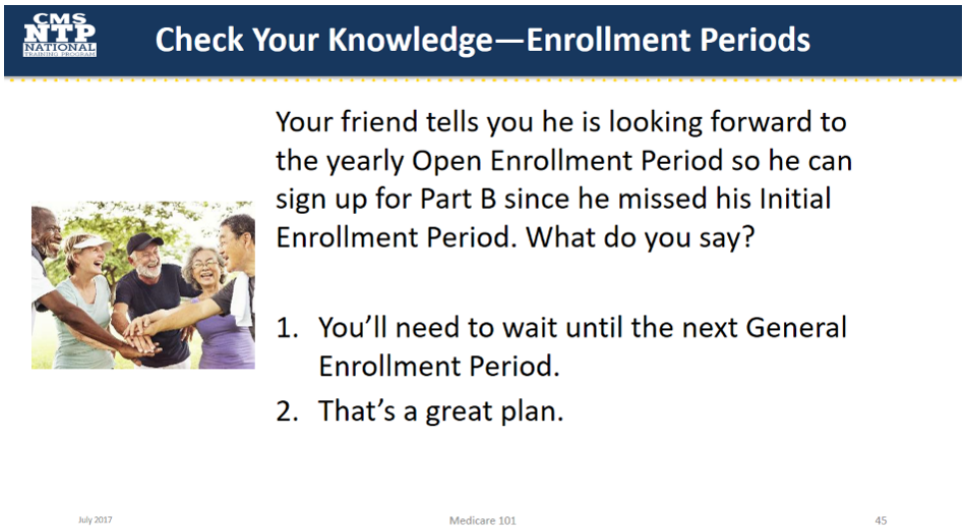

Check Your Knowledge—Enrollment Periods

Circle the Answer

Read the scenario and circle the correct answer (a or b) to the question. See Appendix C for the answer key.

Scenario: Your friend tells you he is looking forward to the yearly Open Enrollment Period so he can sign up for Part B since he missed his Initial Enrollment Period.

What do you say?

a. You'll need to wait until the next General Enrollment Period.
b. That's a good plan.

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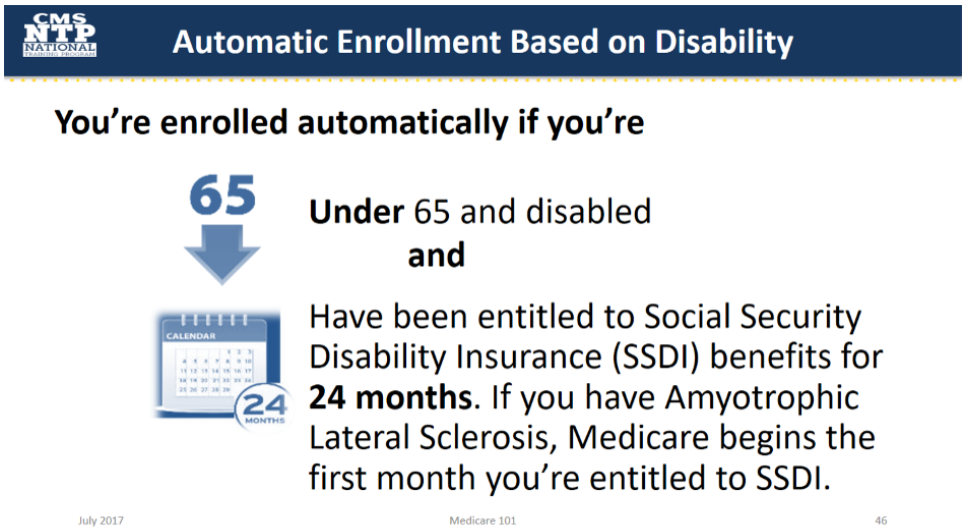
[Slide 46]



Automatic Enrollment Based on Disability

Circle the Answer

Where text is underlined, circle the correct word or number.
See Appendix C for the answer key.

Medicare also covers 2 additional groups:

- People under 65 with a disability who have been entitled to Social Security Disability Insurance (SSDI) benefits for **(12** or **24)** months.
- People with End-Stage Renal Disease (ESRD) who meet special Social Security earnings requirements. People with ESRD don't need to be entitled to Social Security benefits to qualify for Medicare. However, if they're also entitled to disability benefits, they may qualify under both programs. ESRD is discussed later.

When disability benefits begin. In most cases, you must be entitled to disability benefits for 24 months before Medicare can begin. Since there is a **(5** or **6)**-month waiting period for SSDI, the earliest that Medicare can start is usually the 30th month after you become disabled. However, there are 2 exceptions:

- The 5-month waiting period for cash benefits doesn't apply to people who get childhood disability benefits or to some people who were previously entitled to disability benefits (in the past **(5** or **10)** years).
- The 24-month Medicare waiting period doesn't apply to people disabled by Amyotrophic Lateral Sclerosis (ALS, known as Lou Gehrig's Disease). People with ALS get Medicare the **(first** or **third)** month they're entitled to disability benefits.

CMS Classroom Module 13—Medicare for People with a Disability: This self-paced individual learning tool covers eligibility for Social Security programs, eligibility and enrollment in Medicare, Medicare plan options, Medigap policies, Medicaid, help paying health care costs, and sources for additional information. See Appendix A for descriptions and links to this and other CMS Classroom Modules.

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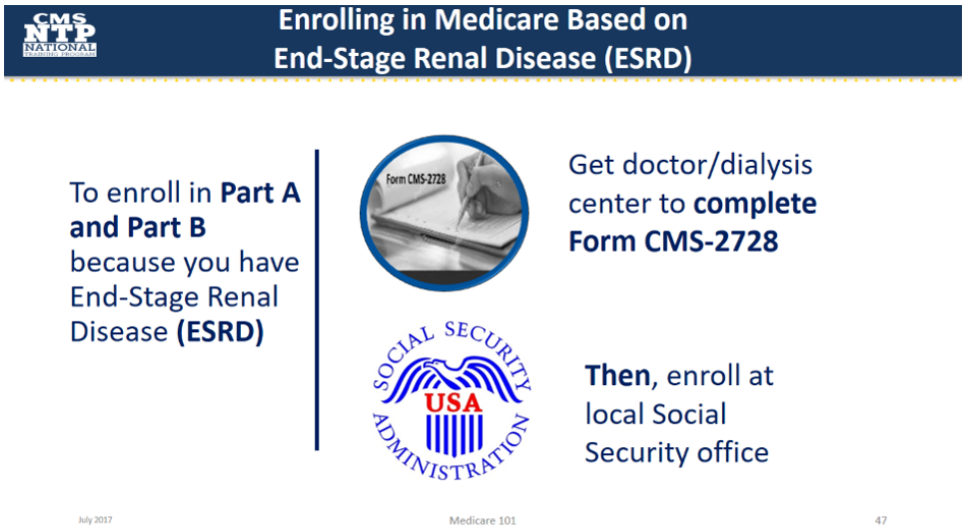

Enrolling in Medicare Because of End-Stage Renal Disease (ESRD)

How to enroll. You can enroll in Medicare Part A and Part B based on ESRD at your local Social Security office. Social Security will need your doctor or the dialysis facility to complete Form CMS-2728 to document that you have ESRD and can get Medicare. If Form CMS-2728 is sent to Social Security before you apply, the office may contact you to ask if you want to complete an application.

Call Social Security at 1-800-772-1213 to make an appointment to enroll in Medicare based on ESRD. TTY: 1-800-325-0778.

The 30-month coordination period. Regardless of the number of employees and whether the coverage is based on current employment status, Medicare is the secondary payer of benefits for the first 30 months of Medicare eligibility (known as the 30-month coordination period) for people with ESRD who have an employer or union group health plan (GHP) coverage.

If your GHP coverage will pay for most or all of your health care costs (for example, if it doesn't have a yearly deductible), you may want to delay enrolling in Part A and Part B until you're getting near the end of the 30-month coordination period. If you delay enrollment, you won't have to pay the Part B premium for coverage you don't need yet. After the 30-month coordination period, you should enroll in Part A and Part B.

If you'll soon receive a kidney transplant. Get the facts about eligibility and enrollment before deciding to delay because there are shorter time periods for eligibility and enrollment deadlines for transplant recipients.

CMS Classroom Module 6—Medicare for People with ESRD: This self-paced individual learning tool covers information for beneficiaries entitled to Medicare because of End-Stage Renal Disease or a disability. See Appendix A for descriptions and links to this and other CMS Classroom Modules.

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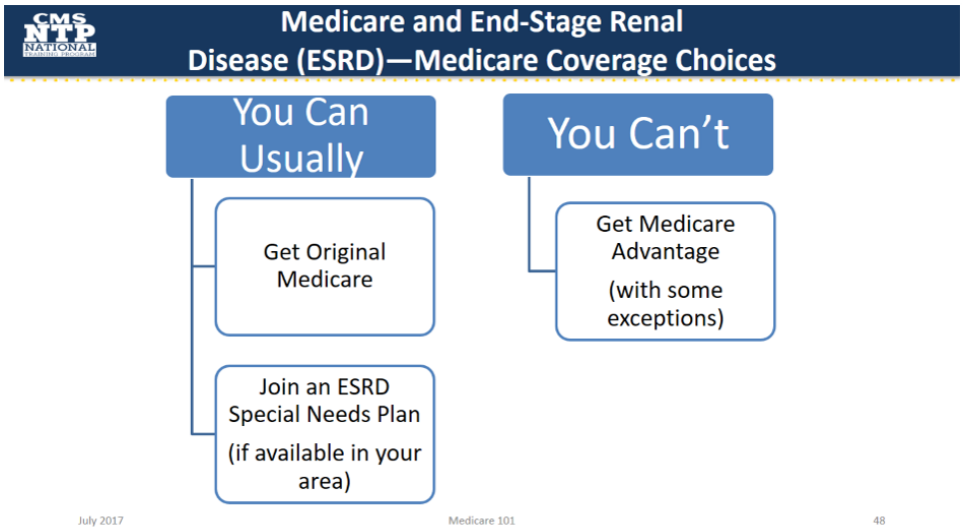
[Slide 48]



Medicare and End-Stage Renal Disease (ESRD)—Medicare Coverage Choices

If you have ESRD and are new to Medicare, you'll most likely get your health care through Original Medicare. You may also have the option of joining a Medicare Special Needs Plan, if one is available in your area for people with ESRD. There are only limited exceptions that allow a person with ESRD to enroll in a Medicare Advantage Plan, like a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO). One example is if their current Employer Group Health Plan has a Medicare option in their area.

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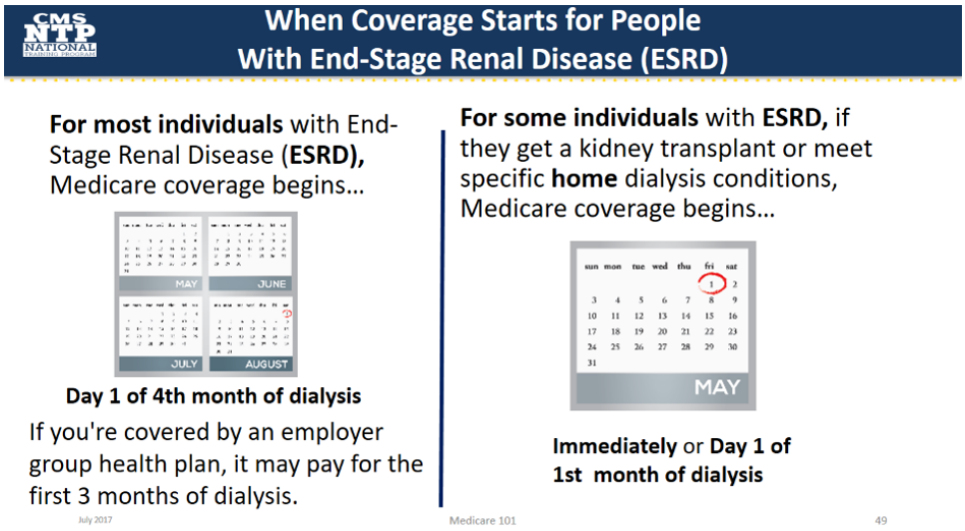
[Slide 49]



When Coverage Starts for People with End-Stage Renal Disease (ESRD)

Circle the Answer

Where text is underlined, circle the correct word or phrase.
See Appendix C for the answer key.

When you enroll in Medicare based on ESRD and you're getting a regular course of dialysis, Medicare coverage usually starts on the **(first** or **last)** day of the **(first** or **fourth)** month of your dialysis treatments. This waiting period will start even if you haven't signed up for Medicare. For example, if you don't sign up until after you've met all the requirements, your coverage could begin up to **(6** or **12)** months before the month you apply.

If you're covered by an employer group health plan, your Medicare coverage will still start the fourth month of dialysis treatments. Your employer group may pay the first **(3** or **6)** months of dialysis.

If you meet all of these conditions, Medicare coverage can start as early as the **(first** or **second)** month of dialysis:

- You take part in a home dialysis training program offered by a Medicare-certified training facility to teach you how to give yourself dialysis treatments at home
- Your doctor expects you to finish training and be able to do your own dialysis treatments
- The regular course of dialysis is maintained throughout the waiting period that would otherwise apply

If you're getting a kidney transplant, Medicare coverage can begin the month you're admitted to a Medicare-certified hospital for a kidney transplant (or for health care services that you need before your transplant) if your transplant takes place in that same month or within the next **(2** or **4)** months.

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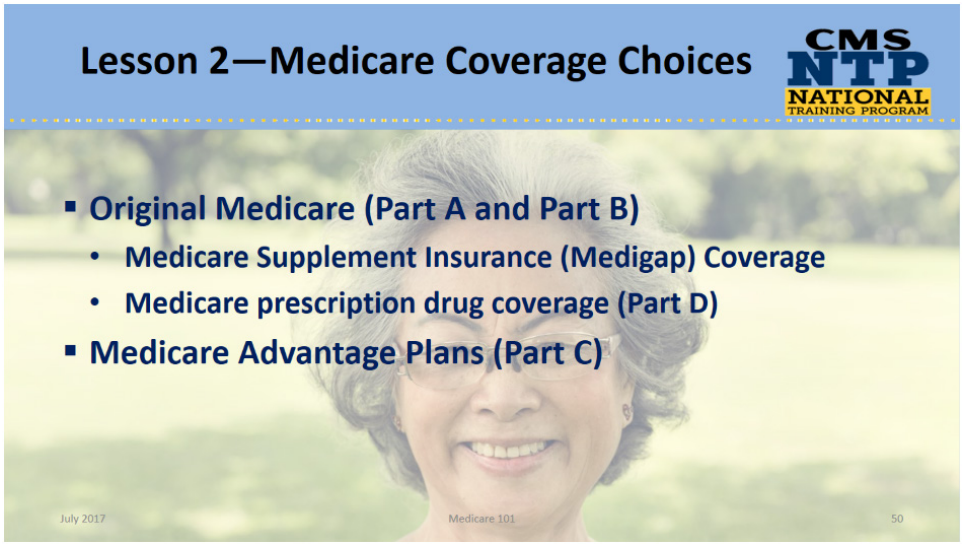
Lesson 2—Medicare Coverage Choices

[Slide 50]



This lesson covers information on how people can choose to get their Medicare, including Original Medicare (Part A and Part B), Medicare Supplement Insurance (Medigap) policies, Medicare Prescription Drug Coverage (Part D), and Medicare Advantage Plans (Part C).

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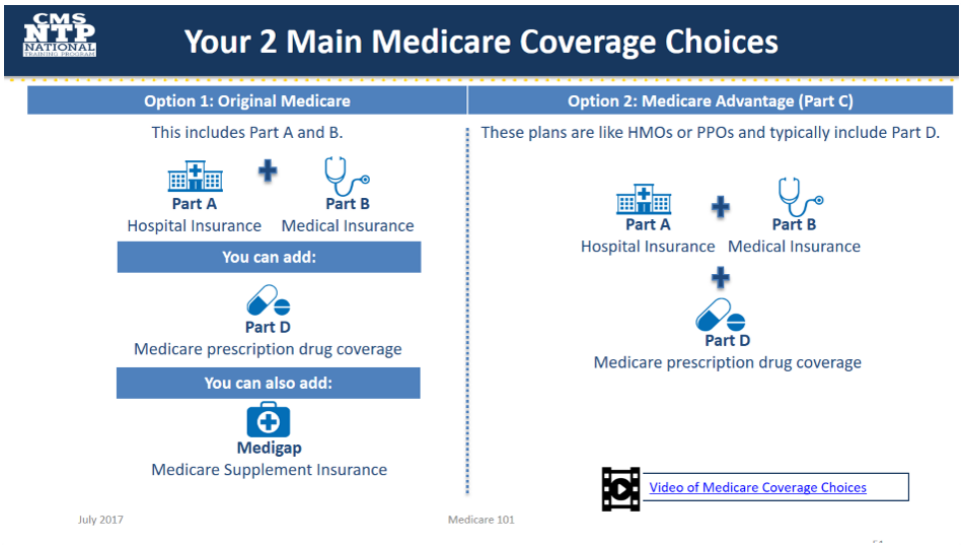
[Slide 51]



Your 2 Main Medicare Coverage Choices

Match Game

Draw a line from each example (1-3) to its description (a-c). See Appendix C for the answer key.

1. Medicare Advantage Plan	a. Part A + Part B
2. Original Medicare	b. Also called Part C
3. Medicare Supplement Insurance	c. Also called Medigap

There are 2 main ways to get your Medicare coverage: Original Medicare, or Medicare Advantage (MA) Plans. You can decide which way to get your coverage.

- **Original Medicare** includes Part A (Hospital Insurance) and/or Part B (Medical Insurance). You can choose to buy a Medigap policy to help cover some costs not covered by Original Medicare. You can also choose to buy Medicare prescription drug coverage (Part D) from a Medicare Prescription Drug Plan (PDP).
- **MA Plans (Part C),** like a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO), cover Part A and Part B services and supplies. They also may include Medicare prescription drug coverage. You can add a Medicare PDP to a Medicare Private Fee-for-Service Plan (if it doesn't provide Part D coverage), and you can add it to a Medicare Medical Savings Account (MSA) Plan. You can't add a Part D plan to a Medicare HMO or PPO plan without drug coverage.
  Medigap policies don't work with these plans. If you join an MA Plan, you can't use a Medicare Supplement Insurance (Medigap) Policy to pay for out-of-pocket costs while you're enrolled in an MA Plan.

In addition to these 2 main options, you may also be able to join other types of Medicare health plans like Medicare Cost Plans or Programs of All-inclusive Care for the Elderly (PACE), or get certain services through demonstrations and pilot programs.

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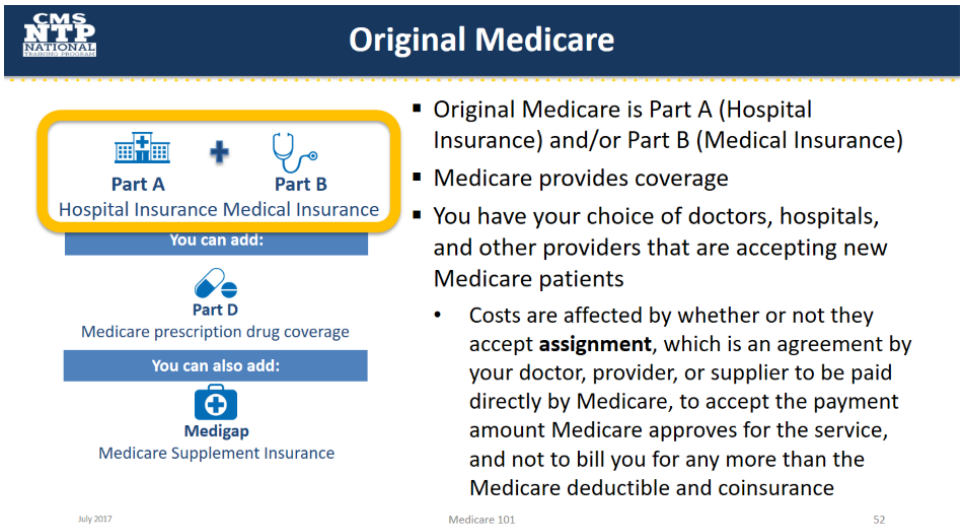
[Slide 52]



Original Medicare

Fill in the Blanks

Choose from the response options. See Appendix C for the answer key.
Response options: *A, B, D, Medigap*

What it is. Original Medicare includes Part _____ (Hospital Insurance) and Part _____ (Medical Insurance). You can choose to buy a _____ policy (you must have both Part A and Part B) to help cover some costs not covered by Original Medicare. You can also choose to buy Medicare prescription drug coverage (Part _____) from a Medicare Prescription Drug Plan (PDP). To buy a PDP you can have Part A only, Part B only, or both.

What it covers. You can go to any doctor, other health care provider, hospital, or other facility that's enrolled in Medicare and is accepting new Medicare patients. Costs are affected by whether or not they accept assignment.

> **Assignment:** An agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

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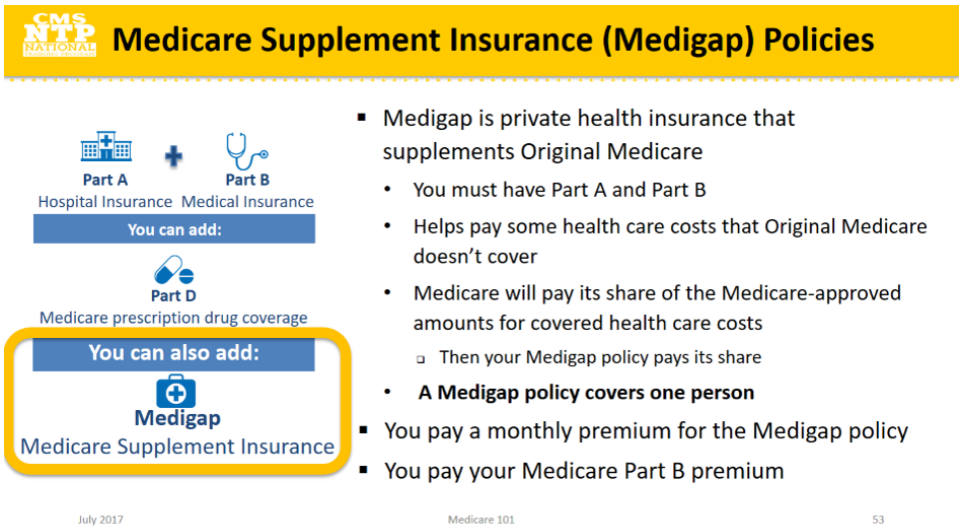

Medicare Supplement Insurance (Medigap) Policies

True or False

Select the correct answer (True or False) for each of the following statements. See Appendix C for the answer key.

1. Medigap policies are purchased through private companies. **(True** or **False)**
2. Medigap policies can cover 2 people. **(True** or **False)**
3. You don't have to pay the monthly Part B premium with a Medigap policy. **(True** or **False)**
4. You must have Part A and Part B to buy a Medigap policy. **(True** or **False)**

What it is. A Medicare Supplement Insurance policy (often called Medigap) is private health insurance that's designed to supplement Original Medicare. This means it helps pay some of the health care costs that Original Medicare doesn't cover (like copayments, coinsurance, and deductibles). If you have Original Medicare and a Medigap policy, Medicare will pay its share of the Medicare-approved amounts for covered health care costs. Then your Medigap policy pays its share. You must have Part A and Part B to buy a Medigap policy.

Who it covers. Medigap policies cover only one person. If you and your spouse both want Medigap coverage, you'll need to have separate Medigap policies.

What you pay. You still pay the monthly Part B premium, in addition to the monthly premium for your Medigap policy.

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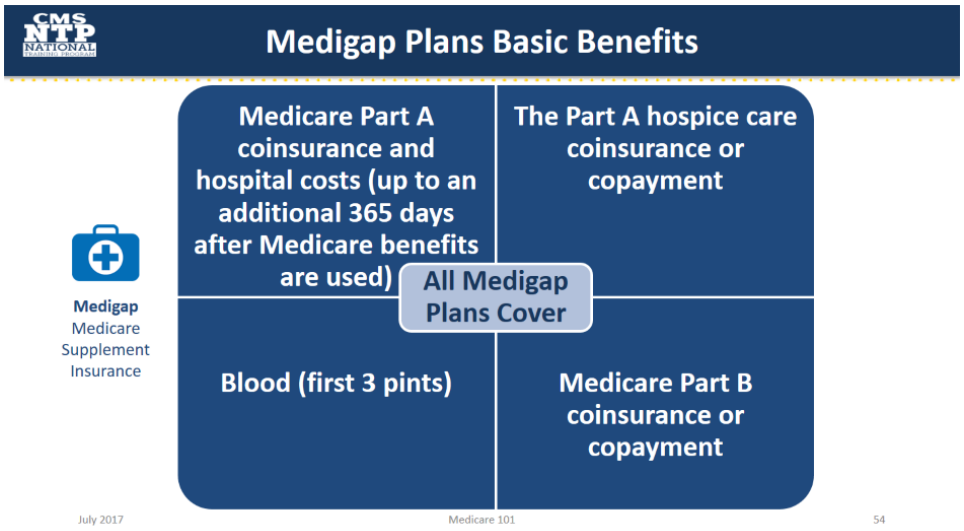
[Slide 54]



Medigap Plans—Basic Benefits

Select the correct answer (True or False) for each of the following statements. See Appendix C for the answer key.

1. Different insurance companies offer different basic benefits for standardized Medigap Plans. **(True** or **False)**
2. All Medigap Plans cover the first 4 pints of blood. **(True** or **False)**

Each standardized Medigap Plan must offer the same basic benefits, no matter which insurance company sells it. These benefits include Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used), Medicare Part B coinsurance or copayments, blood (first 3 pints), and the Part A hospice care coinsurance or copayments.

CMS Classroom Module 3—Medigap: This self-paced individual learning tool covers supplemental insurance policies that pay certain beneficiary health care costs that are not covered under Medicare. See Appendix A for descriptions and links to this and other CMS Classroom Modules.

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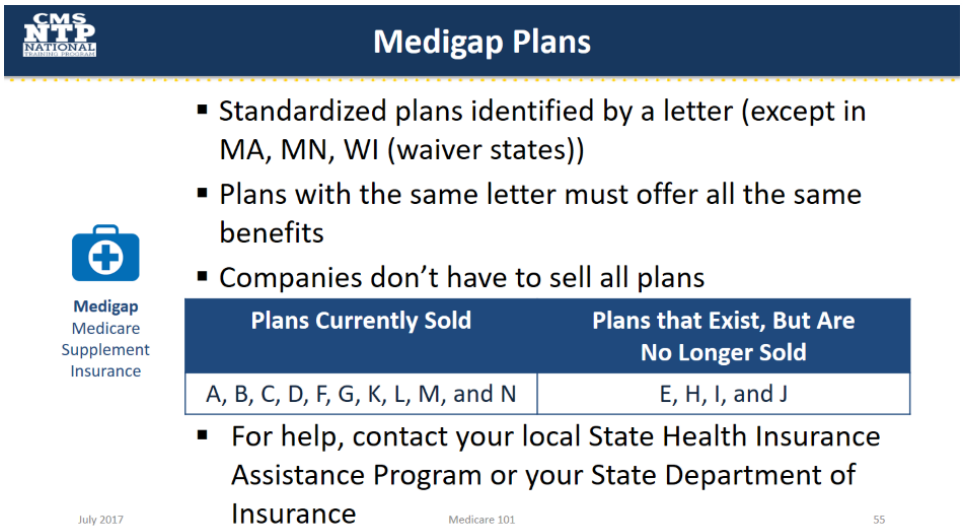
[Slide 55]



Medigap Plans—Differences in Policies

Circle the Answer *Where text is underlined, circle the correct word or phrase. See Appendix C for the answer key.*

Standardized plans. In most states, Medigap insurance companies can only sell you a standardized Medigap policy identified by letters A, B, C, D, F, G, K, L, M, and N. Plans D and G with an effective date on or after June 1, **(2010** or **2015)**, have different benefits than Plans D and G bought before June 1, 2010. Plans E, H, I, and J are no longer sold, but if you already have one, you can generally keep it. Plan F has a high-deductible option.

Plans with the same letter. The benefits in any Medigap Plan identified with the same letter are **(the same** or **different)** regardless of which insurance company you purchase your policy from. **(Benefits covered** or **cost)** is usually the only difference between Medigap plans with the same letter sold by different insurance companies. You're encouraged to shop carefully for a Medigap policy.

Available plans. Insurance companies selling Medigap policies are required to make Plan **(A** or **B)** available. If they offer any other Medigap plan, they must also offer either Medigap Plan C or Plan F. Not all types of Medigap policies may be available in your state. Call your State Health Insurance Assistance Program (SHIP) (1-877-839-2675) or visit shiptacenter.org for more information and to locate the SHIP in your state.

Plans purchased prior to standardization. Some people may still have a Medigap policy they purchased before the plans were standardized. If they do, they (**can** or **cannot)** keep them. If they drop them, they may not be able to get them back.

Waiver states. Medigap policies are standardized in a different way in **(Massachusetts, Minnesota, and Wisconsin** or **Pennsylvania, New Hampshire, and Oregon)**. These are called waiver states.

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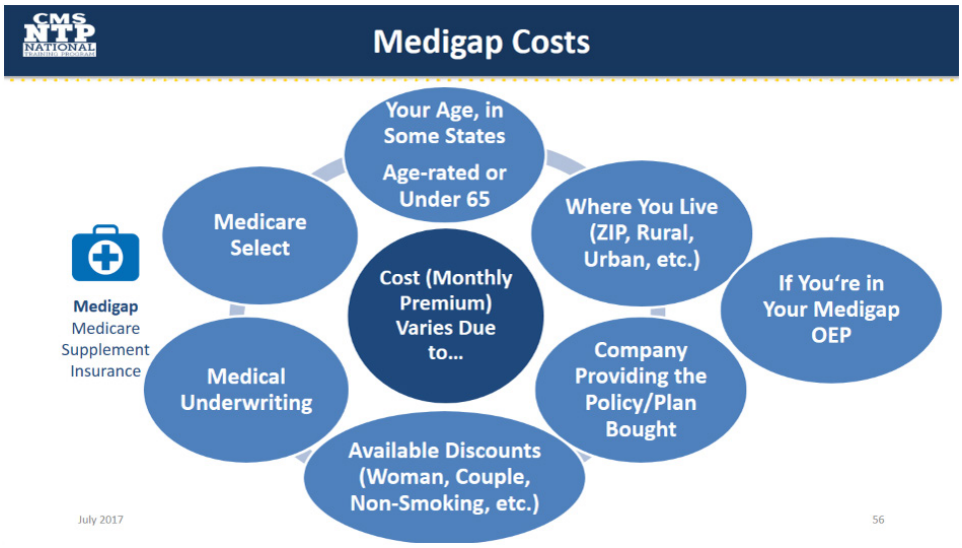

Medigap Costs

Choose from the response options. See Appendix C for the answer key.
Response options: *age, company, less, medical history, nonsmokers, Plan F, premiums, where you live.*

There can be big differences in the _____that different insurance companies charge for exactly the same coverage. Costs depend on your_____ (in some states), _____ (for example, urban, rural, or ZIP code), and the _____selling the policy.

The cost of your Medigap policy may also depend on whether the insurance company does any of the following:

- **Offers discounts** (such as discounts for women, _____, or people who are married; discounts for paying yearly; discounts for paying your premiums using electronic funds transfer; or discounts for multiple policies).
- **Uses medical underwriting** (reviews your_____ _____to decide whether to accept your application, and add a waiting period for a pre-existing condition, if your state law allows it); **or applies a different premium** when you don't have a guaranteed issue right, or aren't in your Medigap Open Enrollment Period (OEP). If you buy it during your Medigap OEP, you get the best cost.
- **Sells Medicare SELECT policies** that may require you to use certain providers. If you buy this type of Medigap policy, your premium may be _____.
- **_____ offers a high-deductible option** for Medigap.

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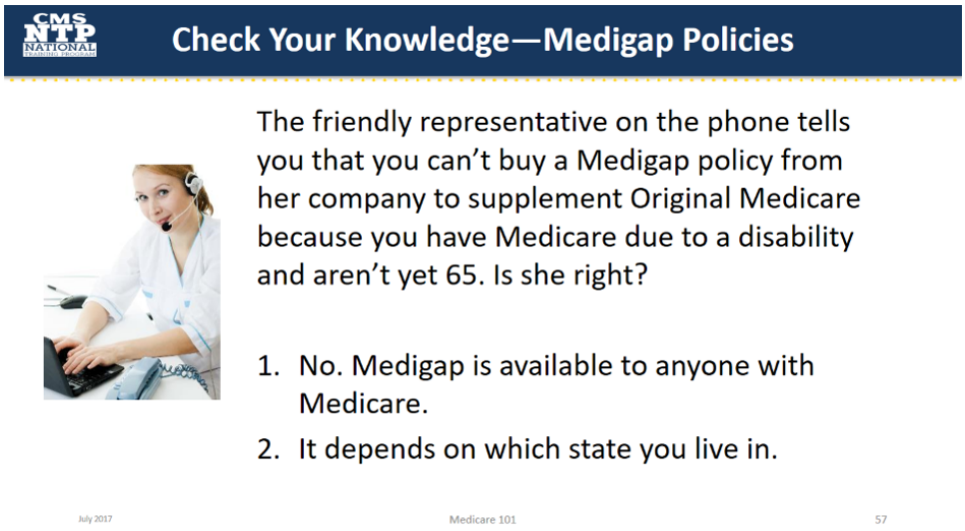

Check Your Knowledge—Medigap Policies

Circle the Answer

Read the scenario and circle the correct answer (a or b) to the question that follows it. See Appendix C for the answer key.

Scenario: The friendly representative on the phone tells you that you can't buy a Medigap policy from her company to supplement Original Medicare because you have Medicare due to a disability and aren't yet 65.

Question: Is she right?

a. No. Medigap is available to anyone with Medicare.

b. It depends on which state you live in.

Federal law doesn't require insurance companies to sell Medigap policies to people under 65. If you're under 65, you might not be able to buy the Medigap policy you want, or any Medigap policy, until you turn 65. However, some states require Medigap insurance companies to sell you a Medigap policy, even if you're under 65.

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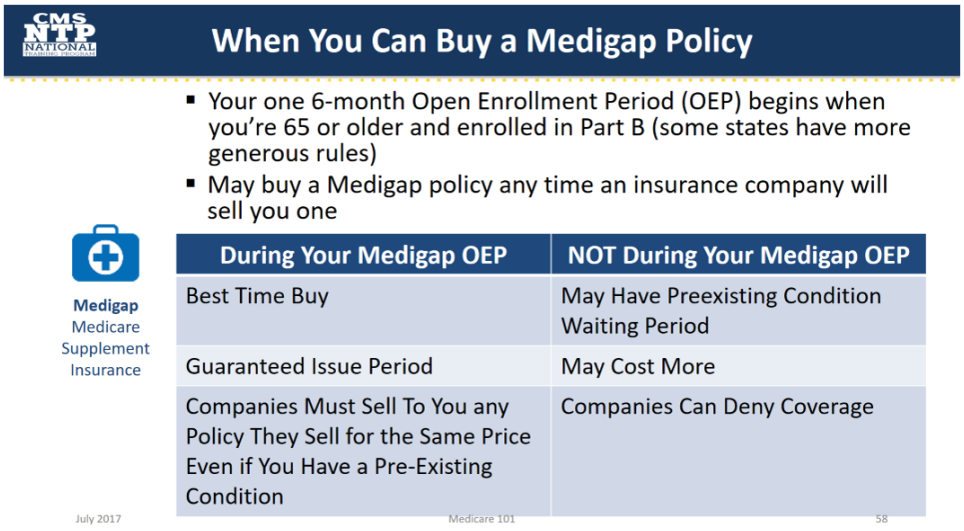
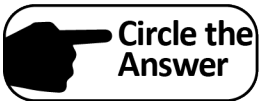


When You Can Buy a Medigap Policy



Select the correct answer (True or False) for each of the following statements. See Appendix C for the answer key.

1. The best time to buy a Medigap policy is during your Medigap Open Enrollment Period (OEP). **(True** or **False)**
2. If you don't buy a Medigap policy within your OEP, insurance companies may deny you coverage based on your health conditions. **(True** or **False)**
3. Your Medigap OEP lasts for 12 months. **(True** or **False)**

Medigap Open Enrollment Period. The best time to buy a Medigap policy is during your Medigap OEP. This period lasts for 6 months and begins on the first day of the month in which you're both 65 or older and enrolled in Medicare Part B.

Benefits of buying during Medigap OEP. If you apply during your Medigap OEP, you can buy any Medigap policy the company sells, even if you have health problems, for the same price as people with good health. If you don't purchase a plan within your 6-month OEP, insurance companies can deny coverage based on your health conditions.

It's also important to understand that your Medigap rights may depend on when you choose to enroll in Medicare Part B. If you're 65 or older, your Medigap OEP begins when you enroll in Part B, and it can't be changed or repeated. In most cases, it makes sense to enroll in Part B and purchase a Medigap policy when you're first eligible for Medicare, because you might otherwise have to pay a Part B late enrollment penalty, and you might miss your Medigap OEP. However, there are exceptions if you have employer coverage.

Coverage for pre-existing conditions. While the insurance company can't make you wait for your coverage to start, it may be able to make you wait for coverage related to a pre-existing condition. Remember, for Medicare-covered services, Original Medicare will still cover the condition, even if the Medigap policy won't cover your out-of-pocket expenses. You may buy a Medigap policy any time an insurance company will sell you one.

State-specific Medigap OEPs. Some states have additional Medigap OEPs, including those for people under 65.

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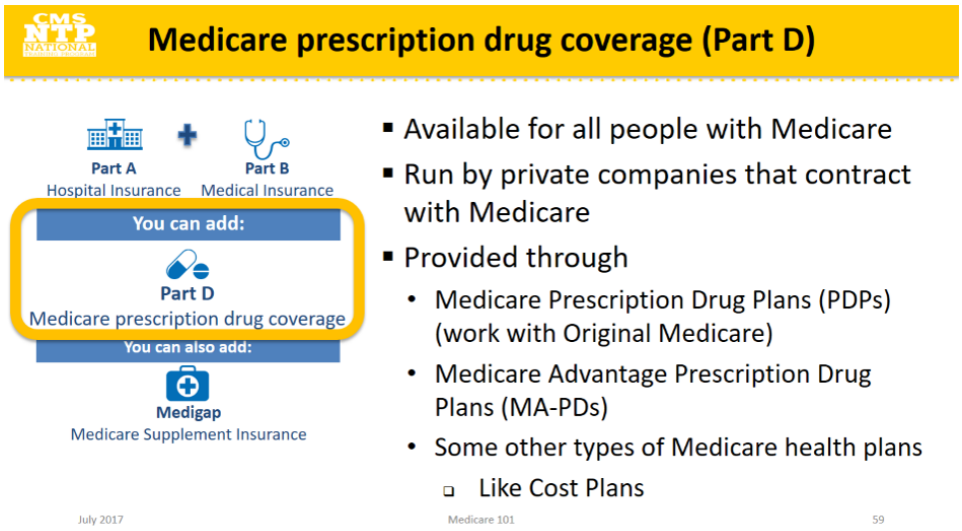

Medicare Prescription Drug Coverage (Part D)

If you have Original Medicare. If you chose Original Medicare and you want prescription drug coverage, you must choose and join a Medicare Prescription Drug Plan. These plans are run by private companies that contract with Medicare. You usually pay a monthly premium.

If you have a Medicare Advantage (MA) Plan. Most MA Plans cover prescription drugs. If yours doesn't, you may be able to join a separate Part D plan.

If you have another type of Medicare health plan. There are some other types of Medicare health plans that provide health care coverage that aren't MA Plans, but are still part of Medicare, such as Medicare Cost Plans and Programs of All-inclusive Care for the Elderly (PACE). Some of these plans provide Medicare Part A and Part B coverage, while others provide Part B coverage only. Some also provide Part D. These plans have some of the same rules as MA Plans. However, each type of plan has special rules and exceptions, so you should contact any plans you're interested in to get more details.

For help choosing a Part D Plan, contact your local State Health Insurance Assistance Program (SHIP). To find the contact information for your local SHIP visit shiptacenter.org.

NTP NATIONAL TRAINING PROGRAM MODULE 9

CMS Classroom Module 9—Medicare Part D Prescription Drug Coverage: This self-paced individual learning tool provides basic information about Medicare prescription drug coverage. See Appendix A for descriptions and links to this and other CMS Classroom Modules.

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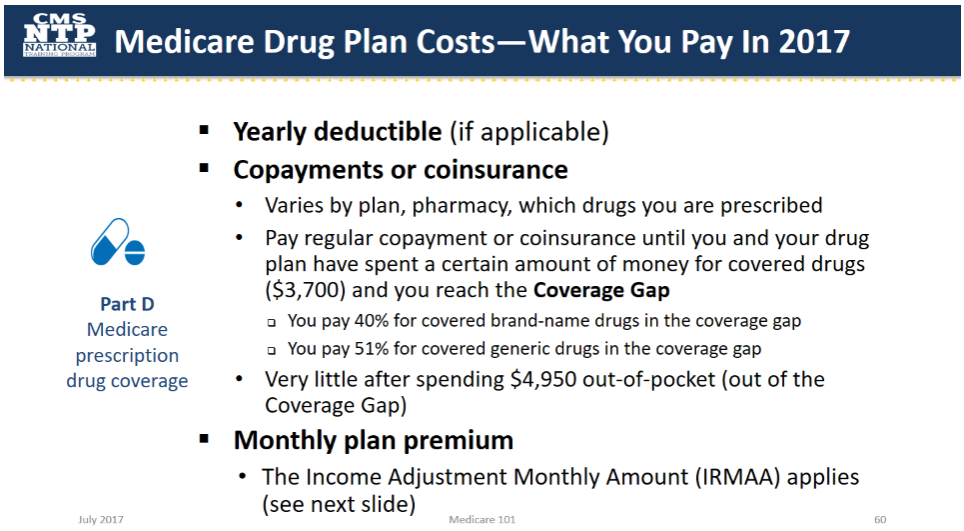

Medicare Drug Plan Costs for 2017

Your costs for prescription drug coverage will depend on the plan you choose and some other factors, like which drugs you use, whether you go to a pharmacy in your plan's network, and whether you get Extra Help paying for your drug costs.

Monthly premiums. Most people will pay a monthly premium for Medicare prescription drug coverage. Contact your drug plan (not Social Security) if you want your premium deducted from your monthly Social Security payment. Your first deduction will usually take 3 months to start, and 3 months of premiums will likely be deducted at once. After that, only one premium will be deducted each month. You may also see a delay in premiums being withheld if you switch plans. If you want to stop premium deductions and get billed directly, contact your drug plan.

Yearly deductible, copayments, and/or coinsurance. In addition to a monthly premium you'll also pay a share of your prescription costs, including a deductible (if applicable), copayments, and/or coinsurance.

- **Entering the coverage gap.** The coverage gap begins after you and your drug plan have spent a certain amount of money for covered drugs ($3,700 in 2017). When you're in the coverage gap, you pay 40% for covered brand-name drugs, and 51% for covered generic drugs.
- **Leaving the coverage gap.** With every plan, once you've paid $4,950 out-of-pocket for drug costs in 2017 (including payments from other sources, like the discount paid for by the drug company in the coverage gap), you leave the coverage gap and pay a small copayment for each drug for the rest of the year.

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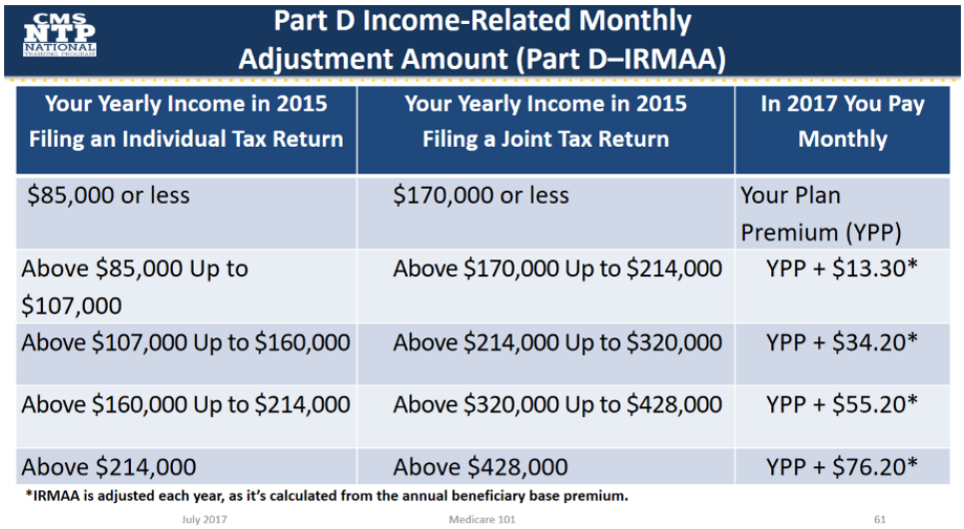

Part D–Income-Related Monthly Adjustment Amount (Part D–IRMA)

Circle the Answer *Where text is underlined, circle the correct word or phrase. See Appendix C for the answer key.*

Who pays only the monthly premium. You pay only your plan premium if your yearly income in 2015 was **($85,000** or **$100,000)** or less for an individual, or **($150,000** or **$170,000)** or less for a couple.

Who pays the monthly premium plus an extra amount. If you reported a modified adjusted gross income of more than $85,000 (individuals and married individuals filing separately) or $170,000 (married individuals filing jointly) on your Internal Revenue Service (IRS) tax return **(3** or **2)** years ago (the most recent tax return information provided to Social Security by the IRS), you'll have to pay an extra amount for your Medicare prescription drug coverage, called the IRMAA. You pay this extra amount **(in addition to** or **instead of)** your monthly Medicare drug plan premium.

Reporting income changes to Medicare. If your income has gone down due to any of the following situations, and the change makes a difference in the income level Social Security considers, contact them to explain you have new information and may need a new decision about your **(IRMAA** or **drug plan premium)**:

- You married, divorced, or became widowed
- You or your spouse stopped working or reduced your work hours
- You or your spouse lost income-producing property due to a disaster or other event beyond your control
- You or your spouse experienced a scheduled cessation, termination, or reorganization of an employer's pension plan
- You or your spouse received a settlement from an employer or former employer because of the employer's closure, bankruptcy, or reorganization

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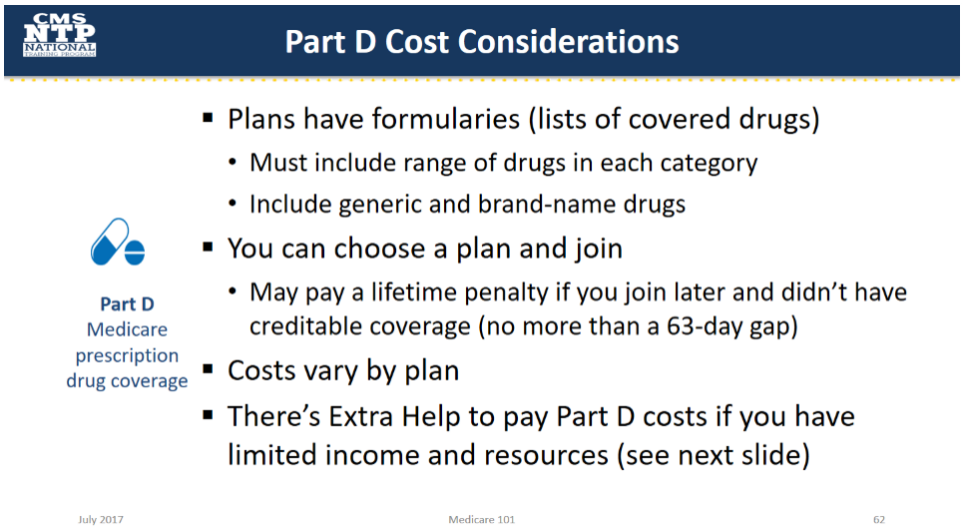
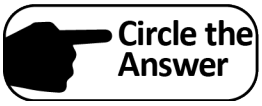


Medicare Part D Considerations



Where text is underlined, circle the correct word or phrase. See Appendix C for the answer key.

Who's eligible. Everyone with Medicare can get Medicare prescription drug coverage by enrolling in a Medicare drug plan. You may get this coverage from a Medicare Advantage Plan (with prescription drug coverage), but you must have Part **(A** or **B)** and Part **(B** or **C)**.

What it costs. Costs vary depending on the plan. Most people **(will** or **won't)** pay a monthly premium for Medicare prescription drug coverage. You'll also pay a share of the cost of your prescriptions, including a deductible (if the plan has one), copayments, and/or coinsurance. You may pay a penalty if you **(cancel** or **join)** later.

What's covered. All Medicare drug plans have to provide at least a standard level of coverage set by Medicare. However, some plans might offer more coverage and additional drugs, generally for a higher monthly premium. Medicare drug plans **(don't** or **must)** cover all drugs in 6 protected categories to treat certain conditions:

1. Cancer medications
2. HIV/AIDS treatments
3. Antidepressants
4. Antipsychotic medications
5. Anticonvulsive treatments for epilepsy and other conditions
6. Immunosuppressants

Also, Medicare drug plans **(don't** or **must)** cover all commercially available vaccines, including the shingles shot (but not vaccines covered under Part B, like the flu and pneumococcal shots), and most compounded medications (as defined in the Code of Federal Regulations' Access to covered Part D drugs, *§423.120(d)*), ecfr.gov/cgi-bin/text-idx?SID=7805cfe316ca233ff673e2e02b0e6b74&mc=true&node=se42.3.423_1120&rgn=div8. You or

your provider can contact your Medicare drug plan for more information about vaccine coverage and any additional information the plan may need.

Each plan has a **formulary**, or list of covered drugs. The formulary for each plan must include a range of drugs in the most commonly prescribed categories. This makes sure that people with different medical conditions can get the treatment they need. All Medicare drug plans generally must cover at least **(2 drugs** or **3 drugs)** in each category of drugs, but plans can choose which specific drugs are covered in each category.

Learn more. For more information, visit CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter6.pdf**.**

Extra Help. If you have limited income and resources, you may qualify for **Extra Help** to pay for your Medicare prescription drug coverage. For information about applying for Extra Help, visit SSA.gov/medicare/prescriptionhelp/.

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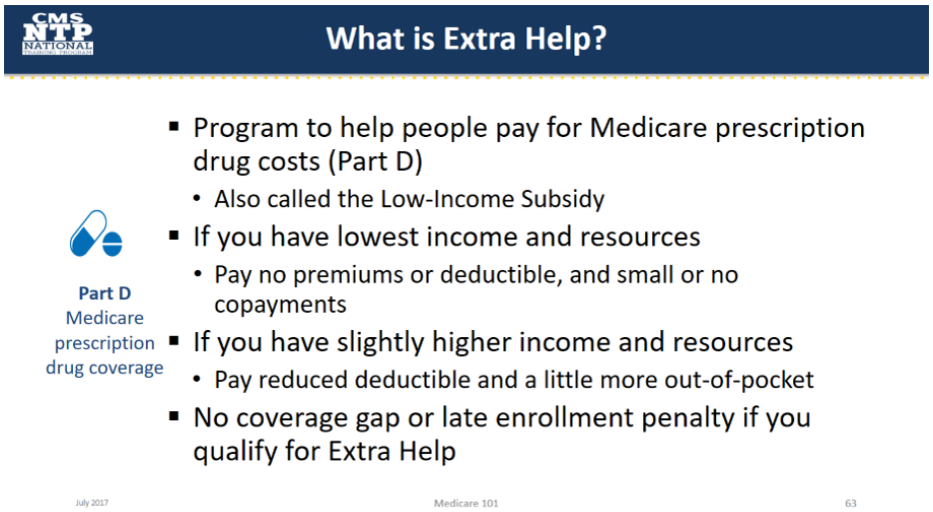

What is Extra Help?

Select the correct answer (True or False) for each of the following statements. See Appendix C for the answer key.

1. The Federal Poverty Level (FPL) guidelines are used to determine the income level requirements for people applying for Extra Help. **(True** or **False)**
2. Everyone who qualifies for Extra Help pays no premiums, deductibles, or copayments. **(True** or **False)**
3. Qualifying for Extra Help may result in a coverage gap. **(True** or **False)**
4. Residents of U.S. territories aren't eligible for Extra Help. **(True** or **False)**

Extra Help is a Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, like premiums, deductibles, and insurance.

Benefits of getting Extra Help. If you have the lowest income and resources, you'll pay no premiums or deductible, and have small or no copayments. If you have slightly higher income and resources, you'll have a reduced deductible and pay a little more out of pocket.

If you qualify for Extra Help, you won't have a coverage gap or late enrollment penalty. You'll also have a continuous Special Enrollment Period and can switch plans at any time, with the new plan going into effect the first day of the next month.

Who's not eligible for Extra Help. Residents of U.S. territories aren't eligible for Extra Help. Each of the territories helps its own residents with Medicare drug costs. This help is generally for residents who qualify for and are enrolled in Medicaid. This assistance isn't the same as Extra Help.

Learn more. See Guide to Consumer Mailings, which are issued in mid-May and late November CMS.gov/Medicare/Prescription-Drug-Coverage/LimitedIncomeandResources/Downloads/Consumer-Mailings.pdf.

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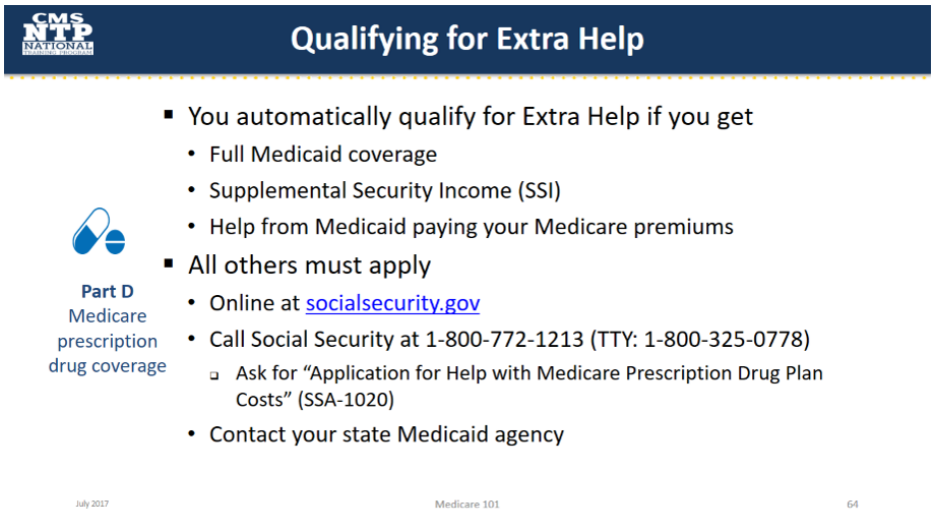

Qualifying for Extra Help

Who automatically qualifies. You automatically qualify for Extra Help (and don't need to apply) if you have Medicare and get full Medicaid coverage, Supplemental Security Income (SSI) benefits, or help from Medicaid paying your Medicare Part B premiums (Medicare Savings Program). Medicare will provide "Extra Help" that may cover 85% to 100% of prescription costs, and may also pay a part or all of your Medicare Part D premiums.

Who needs to apply. If you don't meet one of the above conditions, you may still qualify for Extra Help, but you'll need to apply for it. If you think you qualify but aren't sure, you should still apply. You can apply for Extra Help at any time, and if you're denied, you can reapply if your circumstances change. Eligibility for Extra Help may be determined by either Social Security or your State Medical Assistance (Medicaid) Office.

Guidelines for determining who qualifies. Resource limits are announced in the fall. The Federal Poverty Level (FPL) guidelines are updated annually late in the following January (aspe.hhs.gov/poverty-guidelines). These guidelines are used to determine the income level requirements for people applying for the Medicare Part D Low-Income Subsidy program, also known as the Extra Help program. If you have limited income and resources, you may get Extra Help paying for your Medicare prescription drug costs. You may qualify for Extra Help in 2017 if your yearly income is below $17,820 for a single person (or $24,030 for a married couple living together or even more if you have dependent children or grandchildren living with you), AND if your assets are below $13,640 for a single person (or $27,250 if you're married). These amounts may change each year. You may qualify even if you have a higher income (like if you still work, live in Alaska or Hawaii, or have dependents living with you).

How to apply. You can apply for Extra Help by completing a paper application you can get by calling Social Security at 1-800-772-1213. TTY: 1-800-325-0778. You may also apply online at ssa.gov/i1020; you may also apply through your state Medicaid agency, or by working with a local organization, such as your State Health Insurance Assistance Program.

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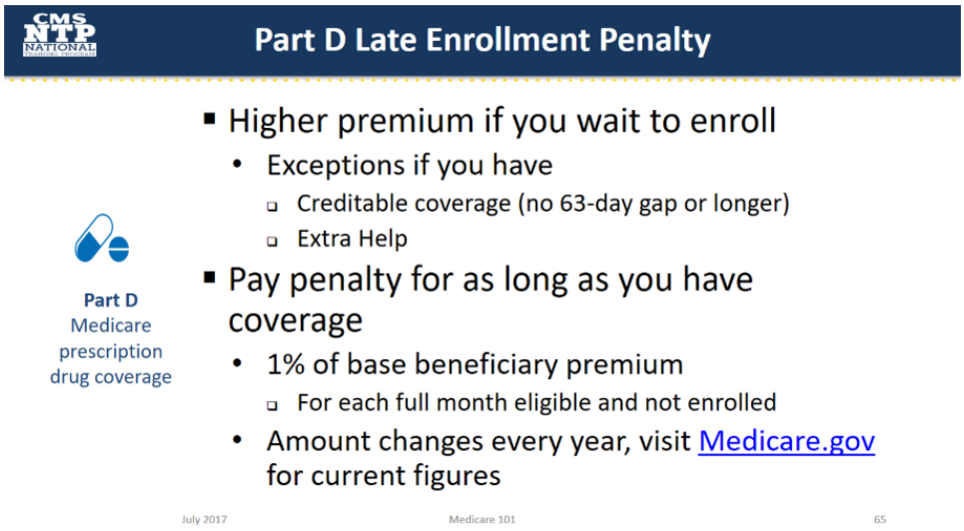

Part D Late Enrollment Penalty

If you choose not to join a Medicare drug plan at your first opportunity, you may have a monthly penalty added to your monthly premium if you enroll later.

Circumstances that can enable you to avoid a penalty. If you have creditable coverage (coverage is expected to pay on average as much as the standard Medicare prescription drug coverage) when you first become eligible for Medicare, you can generally keep that coverage and won't have to pay a penalty if you choose to enroll in a Medicare drug plan later, as long as you join within 63 days after your other drug coverage ends. Also, you won't have to pay a higher premium if you get Extra Help paying for your prescription drugs.

How the penalty is calculated. The late enrollment penalty is calculated by multiplying the 1% penalty rate times the national base beneficiary premium ($35.63 in 2017) times the number of full, uncovered months you were eligible to join a Medicare drug plan but didn't and went without other creditable prescription drug coverage. The penalty calculation isn't based on the premium of the plan in which you're enrolled. The final amount is rounded to the nearest $.10 and added to your monthly premium. The national base beneficiary premium may go up each year, so the penalty amount may also go up each year.

Here is an example of calculating the Part D late enrollment penalty for someone who didn't join Part D when first eligible and didn't have creditable drug coverage for 31 months.

Here's the math:

.31 (31% penalty) × $35.63 (2017 base beneficiary premium) = $11.05
$11.05 (rounded to the nearest $0.10) = $11.10
$11.10 = The monthly late enrollment penalty for 2017 in this case

After you join a Medicare drug plan, the plan will tell you if you owe a penalty, and what your premium will be. You may have to pay this penalty for as long as you have a Medicare drug plan.

Asking Medicare to reconsider a penalty. If you don't agree with your late enrollment penalty, you may be able to ask Medicare for a review or reconsideration. You'll need to fill out a reconsideration request form (that your plan will send you), and you'll have the chance to provide proof that supports your case.

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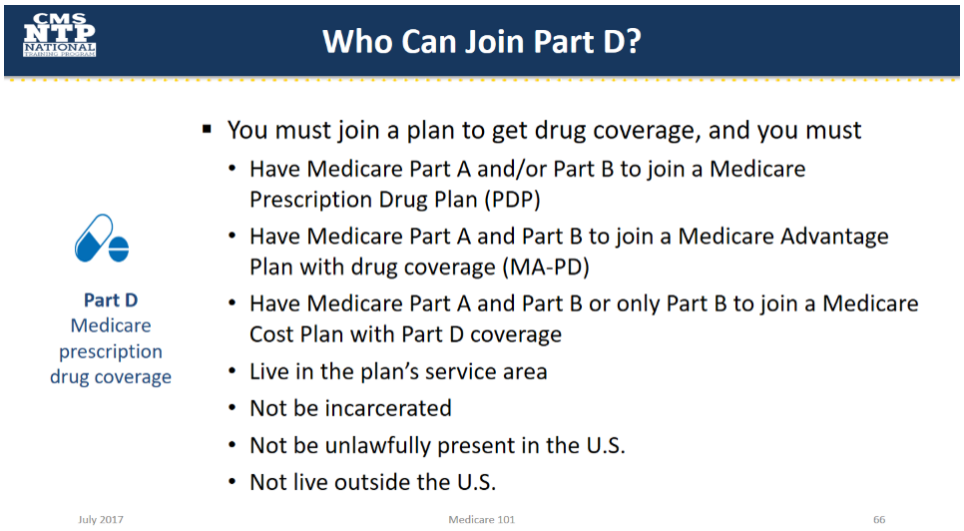

Who Can Join Part D?

True or False

Select the correct answer (True or False) for each of the following statements. See Appendix C for the answer key.

1. Most people will be automatically enrolled in Medicare drug coverage. **(True** or **False)**
2. You must live in the plan's service area to be eligible to join. **(True** or **False)**
3. You can be a member of multiple Medicare drug plans at the same time. **(True** or **False)**

Who's eligible. In general, an individual is eligible to enroll in a Medicare prescription drug plan (PDP) if he or she:

- Is enrolled in Medicare Part A and/or Part B
- Permanently resides in the service area of a PDP
- Is a U.S. citizen or is lawfully present in the United States

Who's not eligible. An individual who's living abroad or is incarcerated isn't eligible for Part D, as he or she can't meet the requirement of permanently residing in the service area of a Part D plan.

Joining a plan. Medicare drug coverage isn't automatic for most people with Medicare. Most people must join a Medicare drug plan to get coverage. So while all people with Medicare can have this coverage, you need to take action to get it. If you qualify for Extra Help to pay for your prescription drugs, Medicare will enroll you in a Medicare drug plan unless you decline coverage or join a plan yourself. You can only be a member of one Medicare drug plan at a time.

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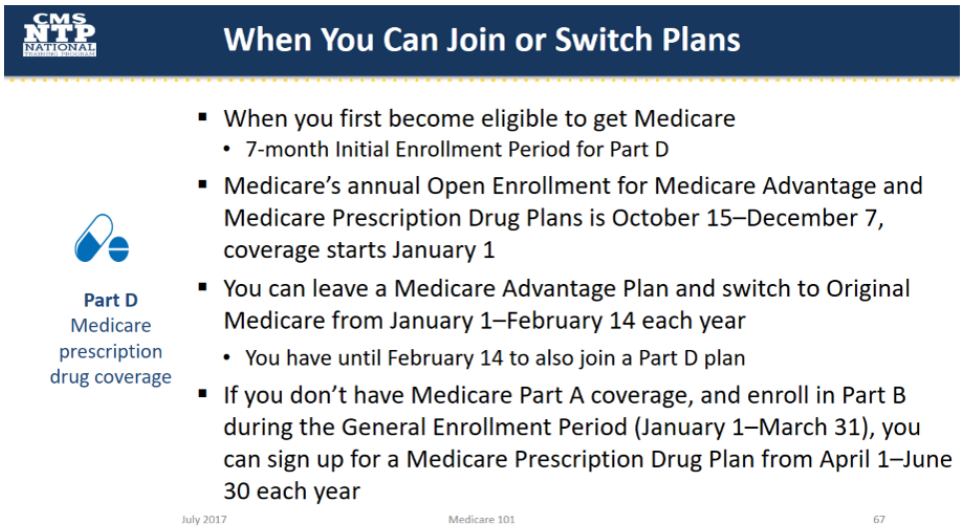

When You Can Join or Switch Plans

True or False

Select the correct answer (True or False) for each of the following statements. See Appendix C for the answer key.

1. When you first become eligible to get Medicare, you have a 7-month Initial Enrollment Period (IEP) for Part D. **(True** or **False)**
2. Medicare's annual Open Enrollment for Medicare Advantage (MA) and Medicare Prescription Drug Plans is January 1–March 1. **(True** or **False)**
3. You cannot leave an MA Plan to switch to Original Medicare. **(True** or **False)**
4. Anyone can sign up for a Medicare Prescription Drug Plan from April 1–June 30. **(True** or **False)**

You can join a Part D plan at the following times:

When you first become eligible for Medicare. When you first become eligible to get Medicare, you have a 7-month Initial Enrollment Period (IEP) for Part D:

- You can apply as early as 3 months before your month of Medicare eligibility. Coverage will start on the date you become eligible for Medicare
- If you apply during your month of eligibility, then your Medicare drug coverage begins the first day of the following month
- You can apply during the 3 months after your month of eligibility, with coverage beginning the first day of the month after the month you apply

During Medicare's annual Open Enrollment for Medicare Advantage (MA) and Medicare Prescription Drug Plans.

- This period is October 15–December 7, with changes going into effect on January 1.

January 1–February 14 each year

- If you're in an MA Plan, you can leave your plan and switch to Original Medicare. If you switch, you have until February 14 to also join a Medicare Prescription Drug Plan to add drug coverage
- Coverage starts the first day of the month after the plan gets the enrollment form

April 1–June 30 (limited)

- If you don't have Medicare Part A, and enroll in Medicare Part B during the Part B General Enrollment Period (January 1–March 31), you can sign up for a Medicare Prescription Drug Plan April 1–June 30. Your coverage begins July 1.

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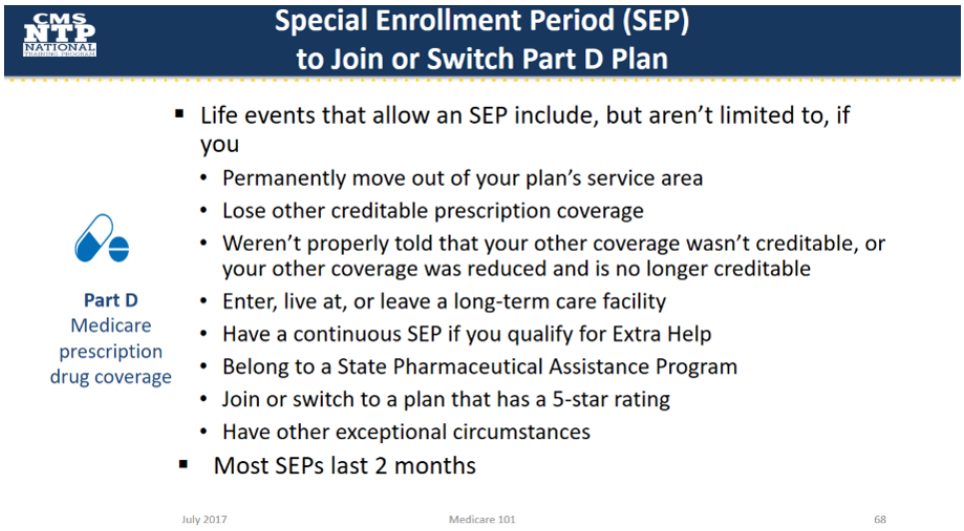

Special Enrollment Period to Join or Switch Part D Plan

Circle the Answer *Where text is underlined, circle the correct number. See Appendix C for the answer key.*

Medicare Part B Special Enrollment Period (SEP)	Medicare Part D SEP
You may be eligible for a Medicare Part B SEP if you're over 65 and you (or your spouse) are still working and have health insurance through current active employment. Your Part B SEP lasts for **(8** or **12)** **months** and begins the month after your employment or employer coverage ends.	Your Part D SEP lasts for only **(2** or **6)** **full** months after the month your coverage ends.

You can change your Medicare prescription drug coverage when certain events happen in your life. These chances to make changes are called SEPs. Each SEP has different rules about when you can make changes and the type of changes you can make. These chances to make changes are in addition to the regular enrollment periods that happen each year. The SEPs listed below are examples. The list doesn't include every situation:

- If you permanently move out of your plan's service area
- If you lose your other creditable prescription drug coverage
- If you weren't properly told that your other coverage wasn't creditable, or that the other coverage was reduced so that it's no longer creditable
- If you enter, live at, or leave a long-term care facility like a nursing home
- If you qualify for Extra Help, you have a continuous SEP, and can change your Medicare drug plan at any time
- If you belong to a State Pharmaceutical Assistance Program
- If you join or switch to a plan that has a 5-star rating (see next page)
- Other exceptional circumstances, like if you no longer qualify for Extra Help

Part B and Part D have different SEPs. It's important to remember that the SEPs for Part B and Part D have different time frames for when you can sign up for coverage.

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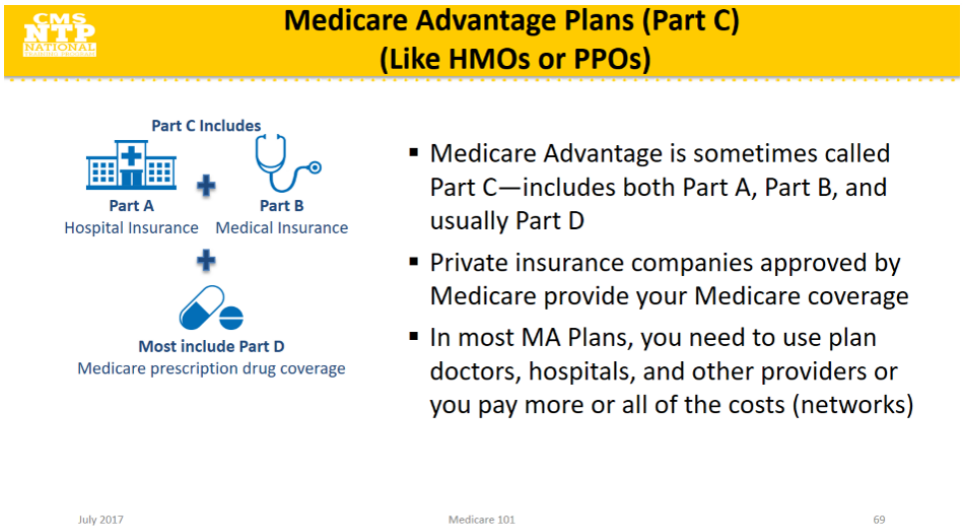

Medicare Advantage Plans (Part C)

Circle the Answer *Where text is underlined, circle the correct word or phrase. See Appendix C for the answer key.*

Another way to get your Medicare coverage is through a Medicare Advantage (MA) Plan.

What's covered. MA Plans (Part C), like a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO), cover **(Part A and Part B** or **only Part A)** services and supplies. They also may include Medicare prescription drug coverage (MA-PD). You can add a Part D plan to a Medicare Private Fee-For-Service, or Medicare Medical Savings Account (MSA) Plan that doesn't have prescription drug coverage included. You **(can** or **can't)** add Part D coverage to an HMO or PPO plan without drug coverage.

Medigap policies don't work with these plans. If you join an MA Plan, you **(can** or **can't)** use your Medicare Supplement Insurance (Medigap) Policy to pay for out-of-pocket costs you have in the MA Plan.

Learn more. Visit Medicare.gov/Pubs/pdf/11135-Prescription-Drug-Coverage-with-MA-MCP.pdf to access the publication *How Medicare Prescription Drug Coverage Works With an MA Plan or Medicare Cost Plan*.

NTP NATIONAL TRAINING PROGRAM MODULE 11

CMS Classroom Module 11—Medicare Advantage Plans: This self-paced individual learning tool provides a comprehensive overview of MA Plans, including who can join, when to join, how the plans work, and what you pay. It's a detailed lesson on marketing guidelines and the ways health plans may or may not market their plans. See Appendix A for descriptions and links to this and other CMS Classroom Modules.

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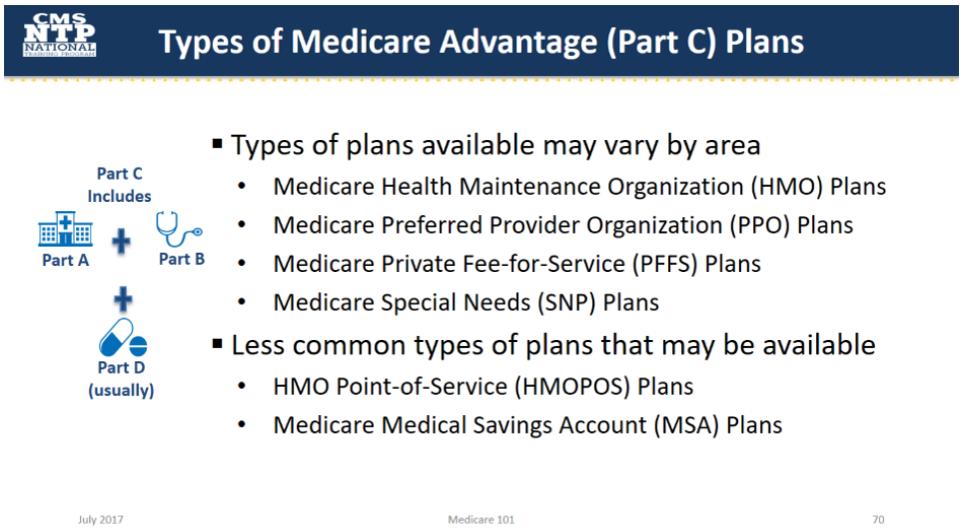

Types of Medicare Advantage (Part C) Plans

Match Game

Draw a line from each example (1-6) to its description (a-f) to indicate which type of Medicare Advantage (MA) Plan it pertains to. See Appendix C for the answer key.

1. Designed to provide focused care tailored to enrollee conditions.	a. Medicare HMO Plans
2. Combines a high-deductible plan with a bank account	b. Medicare Medical Savings Account (MSA) Plans
3. Has a network of doctors and hospitals, and if you go outside of it you might have to pay the full cost	c. Medicare HMO Point-of-Service (HMOPOS) Plans
4. Can go to any Medicare-approved doctor or hospital that accepts the plan's payment terms and agrees to treat you	d. Medicare Special Needs Plans (SNP)
5. Health Maintenance Organization (HMO) plan that allows you to go out of network for certain services, usually for a higher cost	e. Medicare Preferred Provider Organization (PPO) Plans
6. Has a network of doctors and hospitals, but can go out of network for covered services, usually for a higher cost	f. Medicare Private Fee-For-Service (PFFS) Plans

If you join a MA Plan, you may have to use a network of doctors and/or hospitals. The **network** is the facilities, providers, and suppliers your plan has contracted with to provide health care services.

There are 4 main types of MA Plans. Not all types of plans are available in all areas:

- **Medicare HMO Plans**–You get your care and services from doctors or hospitals in the plan's network. If you get care outside the plan network, you may have to pay the full cost. You may need a referral to see certain specialists.

- **Medicare PPO Plans**–You have a network of doctors and hospitals, but with a PPO plan, you can also use out-of-network providers for covered services, usually for a higher cost.
- **Medicare Private Fee-For-Service (PFFS) Plans**–You can go to any Medicare-approved doctor or hospital that accepts the plan's payment terms and agrees to treat you. If you join a PFFS Plan that has a network, you can also see any of the network providers who have agreed to always treat plan members. You can also choose an out-of-network doctor, hospital, or other provider who accepts the plan's terms, but you may pay more.
- **Medicare Special Needs (SNP) Plans**–SNP Plans are designed to provide focused care management, special expertise of the plan's providers, and benefits tailored to enrollee conditions. You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network.

There are 2 less common types of plans that may be available:

- **HMO Point-of-Service (HMOPOS) Plans**–In some HMO plans, you may be able to go out-of-network for certain services, usually for a higher cost. This is called an HMO with a point-of-service (POS) option.
- **Medicare Medical Savings Account (MSA) Plans**–Plans that combine a high-deductible health plan with a bank account. Medicare deposits money into the account, and you use the money to pay for your health care services.

PFFS and MSA plans aren't coordinated care plans. An enrollee in these plan types won't necessarily have a network of providers or a provider to coordinate care.

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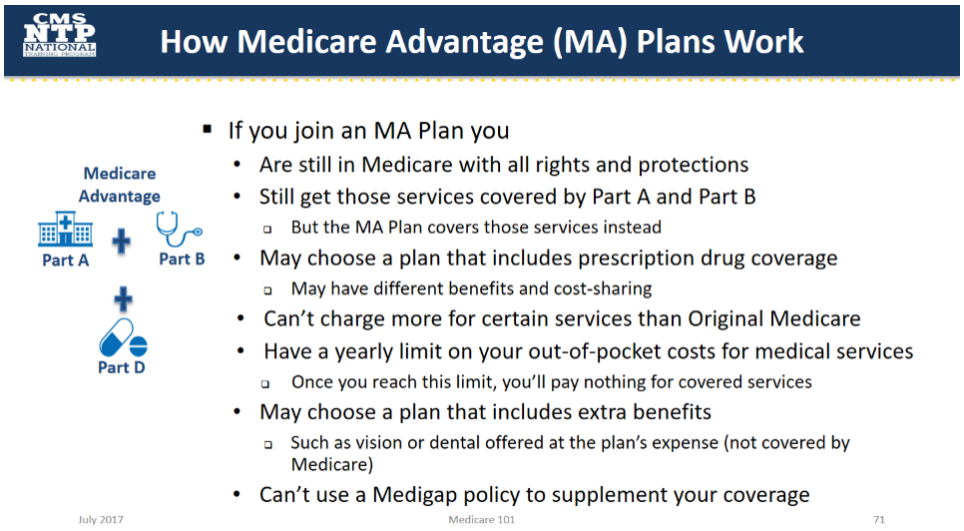

How Medicare Advantage Plans Work

Match Game

Draw a line from each example (1-3) to its description (a-c) to indicate whether it's something included with an Medicare Advantage (MA) Plan. See Appendix C for the answer key.

1. Prescription drug coverage and extra benefits (such as vision or dental)
2. A Medigap policy
3. Medicare rights and protections and services covered by Part A and Part B

a. Always
b. Usually
c. Never

If you join a MA Plan, you

- Are **still in Medicare** with all Medicare rights and protections
- Still get those services covered by Part A and Part B, but the MA Plan covers those services instead (**must have both Part A and Part B** to join an MA Plan)
- May choose a plan that includes **prescription drug coverage** (benefits and cost-sharing may be different)
- May choose a plan that includes **extra benefits** such as vision or dental offered at the plan's expense (not covered by Medicare)

Charges, compared to Original Medicare. MA Plans can't charge more than Original Medicare for certain services like chemotherapy, dialysis, and skilled nursing facility care.

Out-of-pocket limit. MA Plans have a yearly limit on your out-of-pocket costs for medical services. Once you reach this limit, you'll pay nothing for covered services. This limit may be different between MA Plans and can change each year. You should consider this when choosing a plan.

Can't be used with a Medigap policy. You can't use a Medigap policy with an MA Plan.

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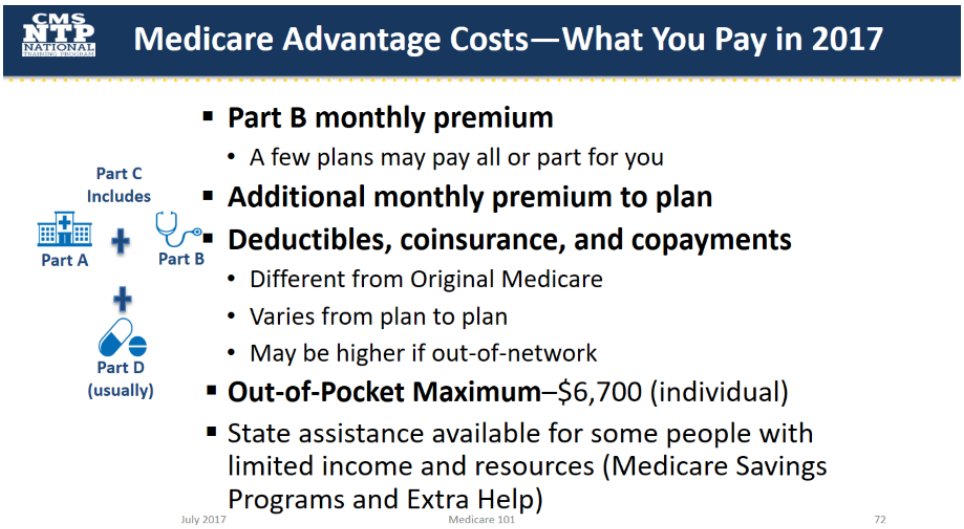

Medicare Advantage Plans—2017 Costs

- **Monthly premium.** If you join a Medicare Advantage (MA) Plan, you must continue to pay the monthly Medicare Part B premium. The Part B premium in 2017 is $109 for most people; $134 for those not "held harmless" (or not protected from an increase in their Part B premium because there was no cost-of-living adjustment for Social Security in 2017). A few plans may pay all or part of the Part B premium for you.
- Some people may be eligible for state assistance (programs for people with Medicare who have limited income and resources).

Other costs. When you join an MA Plan there are other costs you may have to pay, such as

- An additional monthly premium to the plan
- Deductibles, coinsurance, and copayments
- These costs may
  - Be different from Original Medicare
  - Vary from plan to plan
  - Be higher if you go out of network
- The out-of-pocket maximum this year is $6,700

Out-of-pocket limit. MA Plans have a yearly limit on your out-of-pocket costs for medical services. Once you reach this limit, you'll pay nothing for covered services. This limit may be different between MA Plans and can change each year. You should consider this when choosing a plan.

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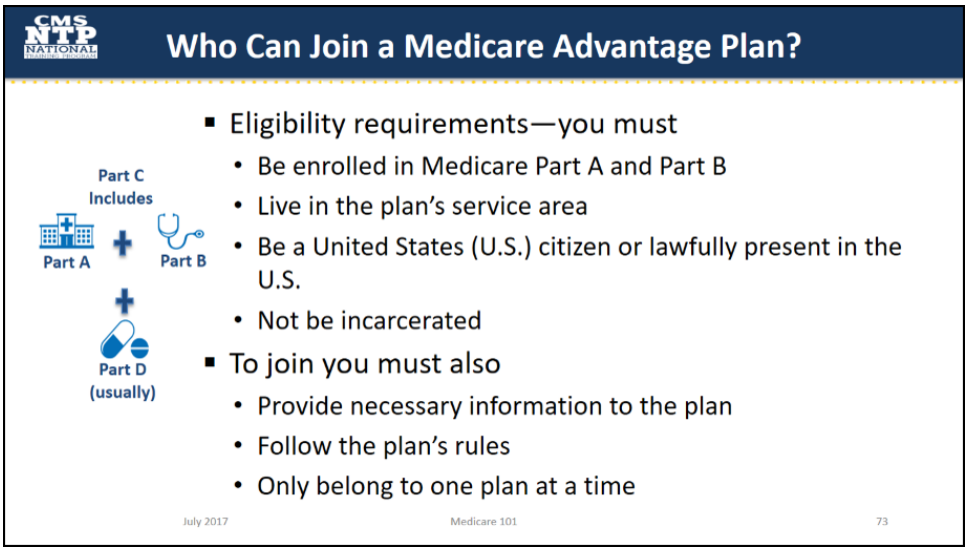

Who Can Join a Medicare Advantage Plan?

Medicare Advantage (MA) Plans are available to most people with Medicare.

Conditions for eligibility. To be eligible to join an MA Plan, you must be enrolled in Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance). You must also live in the plan's geographic service area. You must be a United States (U.S.) citizen or lawfully present in the U.S., and you can't be incarcerated.

Requirements and agreements. To join an MA Plan, you must also agree to

- Provide the necessary information to the plan, such as your Medicare number, address, date of birth, and other important information
- Follow the plan's rules
- Belong to only one MA Plan at a time

Available plans. To find out which MA Plans are available in your area, visit https://www.medicare.gov/find-a-plan/ and follow the directions, or call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

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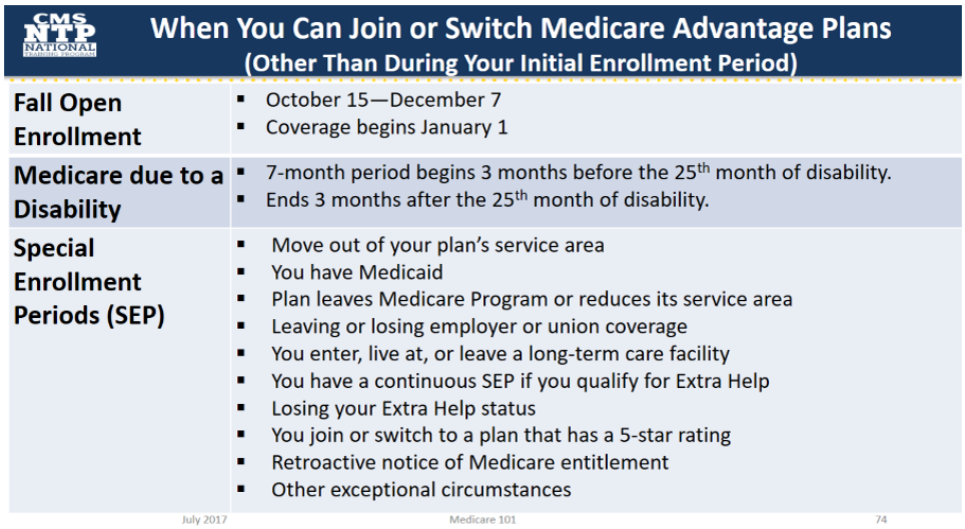

When You Can Join or Switch Medicare Advantage Plans

Select the correct answer (True or False) for each of the following statements. See Appendix C for the answer key.

1. Anyone with Medicare can join, switch, or drop a Medicare Advantage Plan during Fall Open Enrollment. **(True** or **False)**
2. You may qualify for a Special Enrollment Period if you leave or are losing employer or union coverage. **(True** or **False)**

Yearly Open Enrollment Period. After your Initial Enrollment Period, you can join or switch to another Medicare Advantage (MA) Plan during Fall Open Enrollment. This period runs from October 15 through December 7 each year, and anyone with Medicare can join, switch, or drop an MA Plan. Your coverage will begin on January 1, as long as the plan gets your request by December 7.

Medicare due to a disability. If you get Medicare due to a disability, you can join during the 7-month period that begins 3 months before your 25th month of disability and ends 3 months after your 25th month of disability.

Plans must be allowing new members to join. Plans may be prohibited from accepting new members if there's a Centers for Medicare & Medicaid Services (CMS)–approved capacity limit, or a CMS-issued enrollment sanction in effect.

Special Enrollment Period (SEP). You may be able to join or switch plans if any of these special circumstances that grant a SEP apply to you:

- Move out of your plan's service area
- Have Medicaid
- Are enrolled in a plan that decides to leave the Medicare Program or reduce its service area at the end of the year
- Leave or are losing employer or union coverage
- Enter, live at, or are leaving a long-term care facility

- Qualify for Extra Help (you have a continuous SEP, meaning you can enroll in or switch your plan at any time)
- Lose your Extra Help status
- Join or switch to a plan that has a 5-star rating
- Receive notice of retroactive Medicare entitlement
- Other exceptional circumstances

Exceptions. In the case of retroactive entitlement, there are special rules that allow for enrollment in an MA Plan, or Original Medicare and a Medigap policy. More information about conditions that allow an exception can be found in Chapter 2 of the "Medicare Managed Care Manual," Section 30.4, at CMS.gov/medicare/health-plans/healthplansgeninfo/downloads/mc86c02.pdf.

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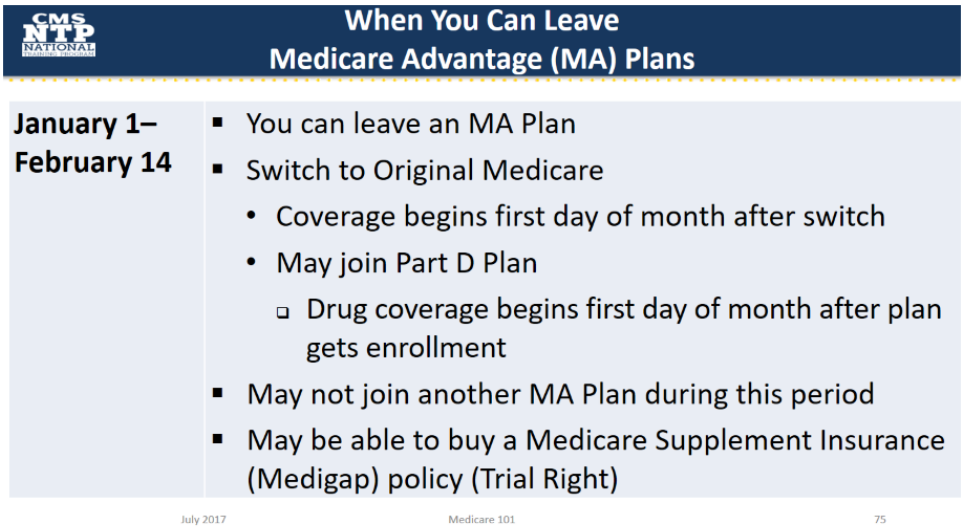
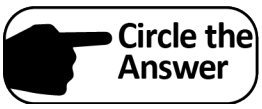


When You Can Leave Medicare Advantage Plans



Where text is underlined, circle the correct word or phrase. See Appendix C for the answer key.

If you belong to a Medicare Advantage (MA) Plan or Medicare Advantage with Prescription Drug (MA-PD) coverage, you can switch to Original Medicare from January 1 through **(February 14** or **March 14)**. If you go back to Original Medicare during this time, plan coverage will take effect on the **(last** or **first)** day of the calendar month following the date on which the election or change was made.

To disenroll from an MA Plan and return to Original Medicare during this period, you can

- Make a request directly to the MA organization.
- Call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

If you make this change, you may also join a Medicare Prescription Drug Plan (PDP) to add drug coverage. Coverage begins the first of the month after the plan receives the enrollment form.

If you leave an MA Plan you may, or may not, be able to buy a Medicare Supplement Insurance (Medigap) Policy. It will depend on your individual circumstances. Certain federal rights may apply. States may provide additional protections. You can buy a Medigap policy any time a plan will sell you one.

You **(may** or **may not)** join another MA Plan during this period. It's important to remember that anytime you enroll in a new MA Plan, MA-PD, or PDP, it **(will** or **won't)** automatically disenroll you from your previous plan. This includes MA-only Health Maintenance Organization and Preferred Provider Organization plans. However, there are limited exceptions for members of MA-only Private Fee-For-Service, Cost and Medicare Medical Savings Account Plans. Once enrolled, coverage begins the first of the month after the plan gets the enrollment form.

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[Slide 76]

Compare Plans on Medicare Plan Finder

Use the Medicare Plan Finder (available at Medicare.gov/find-a-plan/) to do the following:

- Search for drug and health plans
- Personalize your search to find plans that meet your needs
- Compare plans based on quality ratings, benefits covered, costs, and more

You should compare Medicare drug plans based on what's most important to your situation and your drug needs. You may want to ask yourself the following questions:

- Which plan(s) covers the prescriptions I take?
- Which plan(s) gives me the best overall price on all of my prescriptions?
- What's the monthly premium, yearly deductible, and the coinsurance or copayment(s)?
- Which plan(s) allows me to use the pharmacy I want or get prescriptions through the mail?
- Which plan(s) gives me coverage in multiple states, if I need it?
- What star ratings did the plan(s) get?
- Can my coverage start when I want it to?
- Is it likely that I'll need protection against unexpected drug costs in the future?

Special Enrollment Plan (SEP) options will display for you if you enroll through the Medicare Plan Finder at Medicare.gov. By checking any of the listed SEPs, you're certifying that, to the best of your knowledge, you're eligible for an enrollment period. If at a later time it's determined that this information was incorrect, you may be disenrolled from the plan.

For more information on Plan Finder, visit CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library-Items/CMS1239988.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=ascending.

The practice website to be used with approved training scenarios is available at https://training.medicare.gov/?ACA=wU8YVKdS3e. Training scenario test case information is available in Appendix A.

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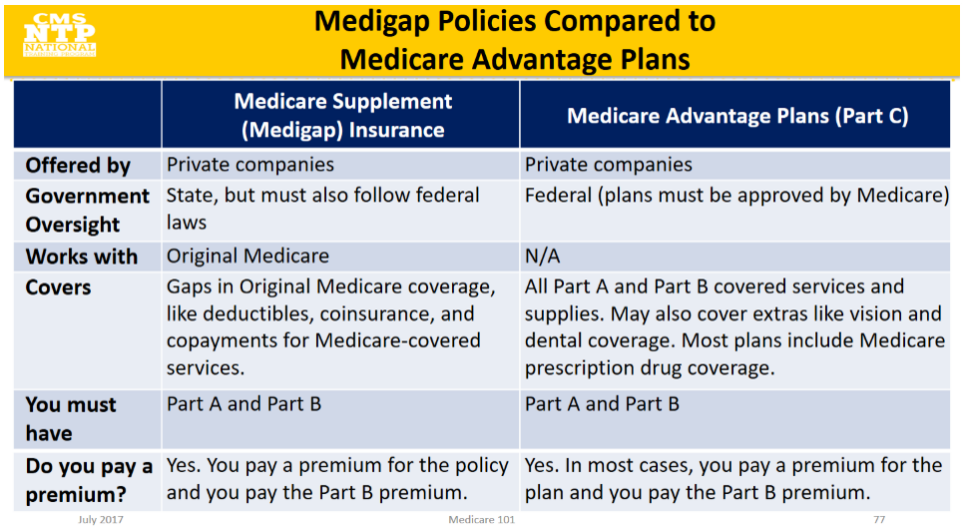
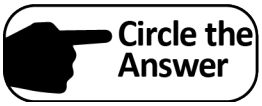


Medigap Policies Compared to Medicare Advantage Plans



Where text is underlined, circle the correct word or phrase. See Appendix C for the answer key.

The above chart displays a side-by-side comparison of Medicare Supplement Insurance (Medigap) Policies and Medicare Advantage (MA) Plans to help explain the differences between how they work.

- **Where to buy**—Both are offered by private companies.
- **Government oversight**—Medigap must follow federal and state laws, but routine day-to-day oversight of standardized Medigap policies are under the purview of the states. MA Plans must be approved by Medicare.
- **Medigap only works with Original Medicare**—MA Plans **(do** or **don't)** work with Medigap policies. If you join an MA Plan, you can't use a Medigap policy to pay for out-of-pocket costs you have in the MA Plan.
- **Original Medicare pays for many, but not all, health care services and supplies**—Private insurance companies sell Medigap policies to help pay for some of the out-of-pocket costs ("gaps") that Original Medicare doesn't cover. Medigap policies **(pay** or **don't pay)** your Medicare premiums. Most Medigap policies don't cover out-of-pocket drug expenses, and you would need to consider a Part D plan. Some older policies (no longer sold) may have included some drug expense coverage (Plan I). MA Plans cover Part A– and Part B–covered services, may include Part D and may cover certain non-covered benefits such as vision and dental.
- **Requirements**—In both cases, you **(must** or **must not)** have Part A **and** Part B to join.
- **Premiums**—You pay a premium for a Medigap policy or an MA Plan, and you pay the Part B premium.
- If you already have an MA Plan, it's illegal for anyone to sell you a Medigap policy unless you're disenrolling from your MA Plan to go back to Original Medicare.

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[Slide 78]

Medicare and the Health Insurance Marketplace

There are things you need to know about Medicare if you have coverage through the Health Insurance Marketplace. These include

- Health Insurance Marketplace Coverage and Medicare
- Marketplace and Becoming Eligible for Medicare

Information about the Federally-facilitated Health Insurance Marketplace is available at HealthCare.gov.

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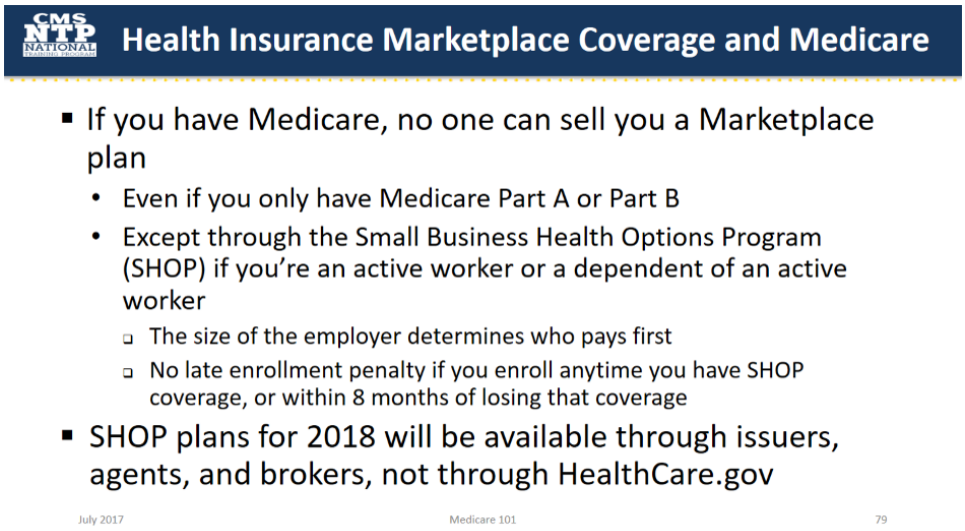

Health Insurance Marketplace Coverage and Medicare

1. It's against the law for someone who knows that you have Medicare to sell you a Marketplace plan. This is true even if you have only Part A or only Part B. The exception is a Marketplace plan through your employer (sold through the Small Business Health Options Program [called SHOP]) if you're an active worker or a dependent of an active worker.
2. SHOP coverage may pay first, before Medicare.
3. If you delay enrollment because you have employer coverage through SHOP, you won't have a late enrollment penalty if you enroll anytime you have SHOP Marketplace coverage, or within 8 months of losing that coverage (if employer has 20 or more employees). This doesn't include COBRA coverage.
4. SHOP Plans will be available for 2018 coverage through issuers, agents, and brokers. They won't be available through HealthCare.gov.

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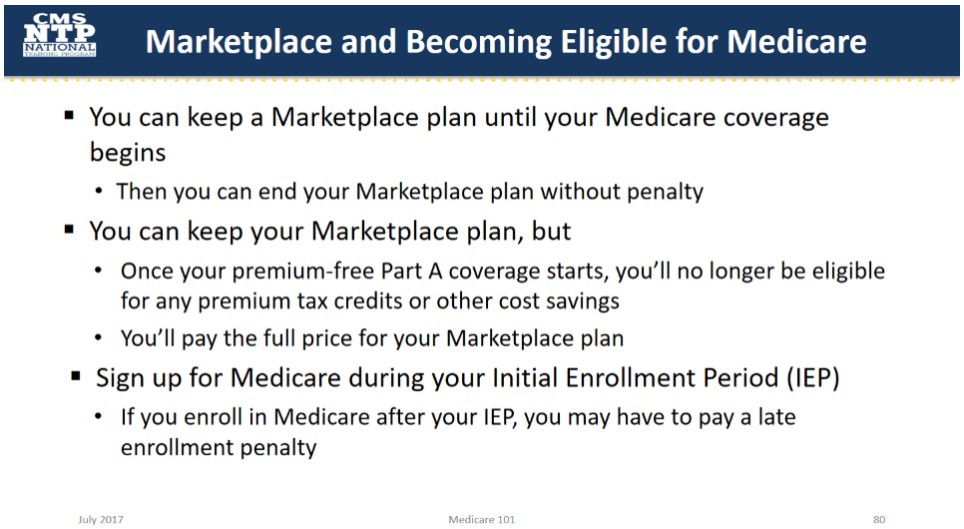
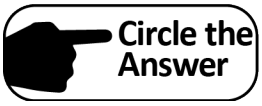


Marketplace and Becoming Eligible for Medicare



Where text is underlined, circle the correct word or phrase. See Appendix C for the answer key.

If you have a Marketplace plan, you can keep it until your Medicare coverage starts. Then you can end your Marketplace plan **(with** or **without)** penalty.

You can keep your Marketplace plan too. But once your Medicare Part A coverage starts, you'll no longer be eligible for any premium tax credits or other cost savings you may be getting for your Marketplace plan. So you'd have to pay **(full** or **half)** price for the Marketplace plan.

When you become eligible for Medicare

Let's assume you have a Marketplace plan and are turning 65 sometime this year.

Once you're eligible for Medicare, you'll have an Initial Enrollment Period (IEP) to sign up for Medicare. For most people, the IEP starts **(3** or **6)** months before their 65th birthday and ends 3 months after their 65th birthday.

In most cases, it's to your advantage to sign up for Medicare when you're first eligible because:

- Once your premium-free Medicare Part A coverage starts, you **(will** or **won't)** be eligible for a premium tax credit or other savings for a Marketplace plan. If you kept your Marketplace plan, you'd have to pay full price.
- If you enroll in Medicare after your IEP ends, you may have to pay a Part B late enrollment penalty for as long as you have Medicare. In addition, you can enroll in Medicare Part B (and Part A if you have to pay a premium for it) **only** during the Medicare General Enrollment Period (from January 1 to March 31 each year). Coverage doesn't start until **(May** or **July)** of that year. This may create a gap in your coverage.

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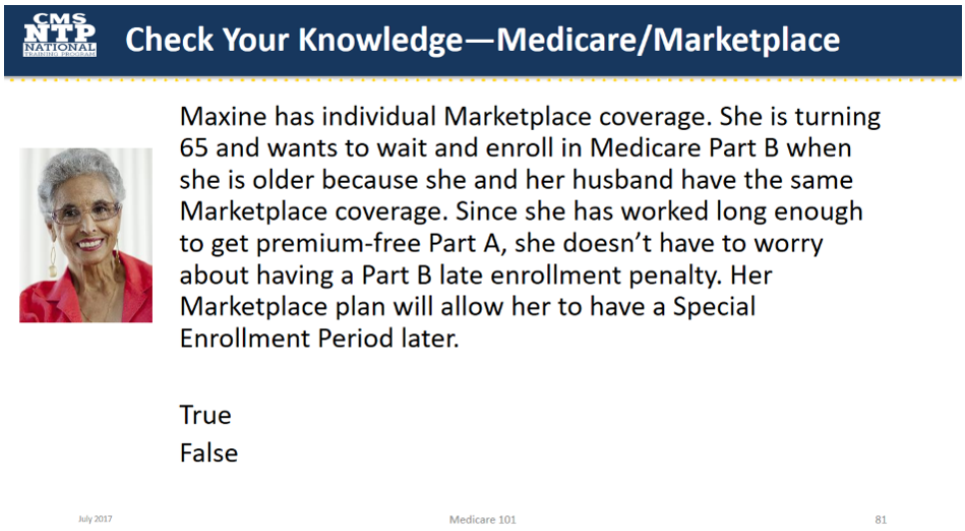

Check Your Knowledge—Medicare/Marketplace (Maxine)

True or False

Select the correct answer (True or False) for the scenario described below. See Appendix C for the answer key.

Scenario: Maxine has individual Marketplace coverage. She is turning 65 and wants to wait and enroll in Medicare Part B when she is older because she and her husband have the same Marketplace coverage. Since she has worked long enough to get premium-free Part A, she doesn't have to worry about having a Part B late enrollment penalty.

Is the following statement true or false? Her Marketplace plan will allow her to have a Special Enrollment Period later. **(True** or **False)**

An individual Marketplace plan is not considered creditable coverage for the purpose of Medicare enrollment. Maxine wouldn't qualify for a Special Enrollment Period and may have to pay a late enrollment penalty for Part B.

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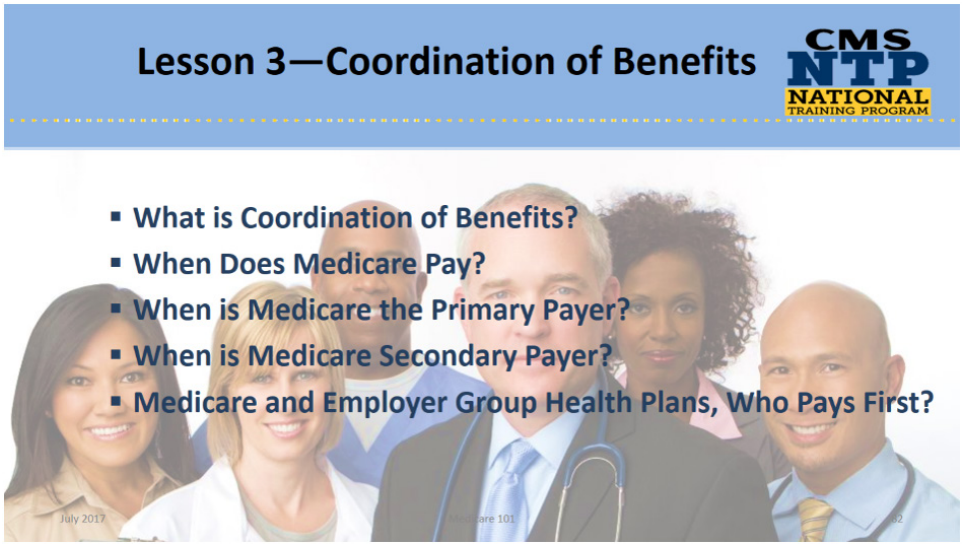
Lesson 3—Coordination of Benefits

[Slide 82]



Lesson 3 explains how benefits are coordinated if a person with Medicare has other types of health care coverage. This lesson answers the following questions:

- What is Coordination of Benefits?
- When Does Medicare Pay?
- When is Medicare the Primary Payer?
- When is Medicare the Secondary Payer?
- Medicare and Employer Group Health Plans: Who Pays First?

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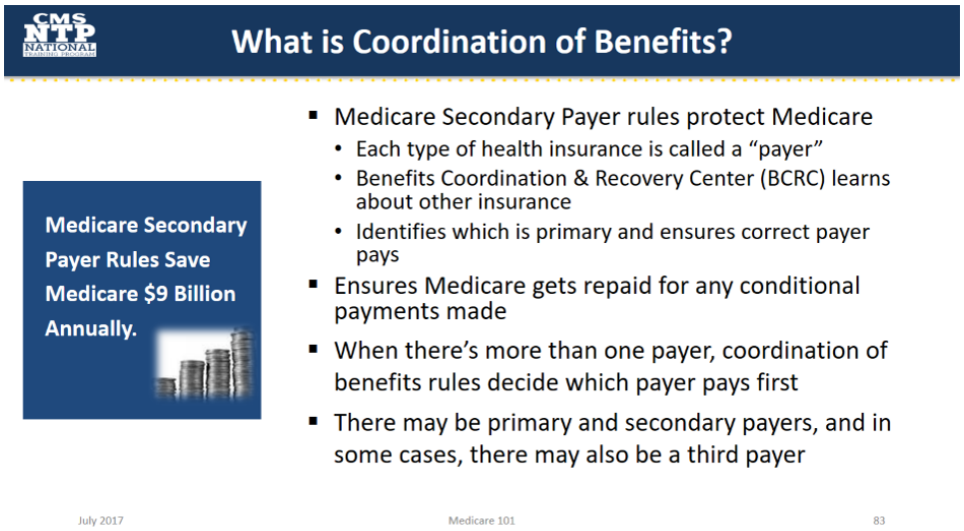

What is Coordination of Benefits?

Circle the Answer

Where text is underlined, circle the correct word or phrase.
See Appendix C for the answer key.

Coordination of **(benefits** or **insurance)** is a way to figure out who pays first when 2 or more health insurance plans are responsible for paying the same medical claim.

If you have Medicare and other health or drug coverage, each type of coverage is called a payer. When there's more than one payer, coordination of **(benefits** or **insurance)** rules decide which payer pays first.

The primary payer pays what it owes on your bills first, and then your provider sends the rest to the secondary payer to pay. In some cases, there may also be a third payer.

NTP NATIONAL TRAINING PROGRAM MODULE 5

CMS Classroom Module 5—Coordination of Benefits: This self-paced individual learning tool covers payers' responsibility when people have Medicare and certain other types of health and/or prescription drug coverage. See Appendix A for descriptions and links to this and other CMS Classroom Modules.

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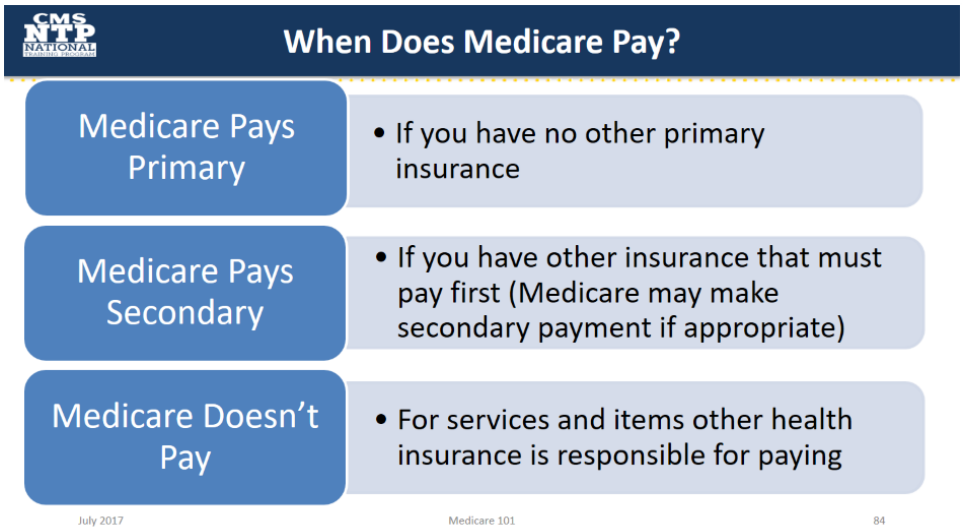

What Determines Whether Medicare Pays First, Second, or Not at All?

Circle the Answer

Where text is underlined, circle the correct word or phrase. See Appendix C for the answer key.

Medicare can be the primary payer, the secondary payer, or sometimes other insurance plans should pay and Medicare shouldn't pay at all.

Primary: Medicare may be the primary payer if you **(do** or **don't)** have other insurance, or if Medicare is primary to your other insurance.

Secondary: Medicare may be the secondary payer in situations where Medicare doesn't provide your primary health insurance, or when another insurer **(is** or **isn't)** primarily responsible for paying.

Not at all: Medicare may not pay at all for services and items that other health insurers **(are** or **are not)** responsible for paying.

Learn more: For more information, see Medicare.gov/Pubs/pdf/02179-Medicare-Coordination-Benefits-Payer.pdf (CMS Product No. 02179) or ecfr.gov/cgi-bin/text-idx?SID=4197918d7a58c79361d4f698fa25219e&mc=true&node=se42.2.411_120&rgn=div8 (42 C.F.R., Chapter IV, Section 411.20, Paragraph 2)

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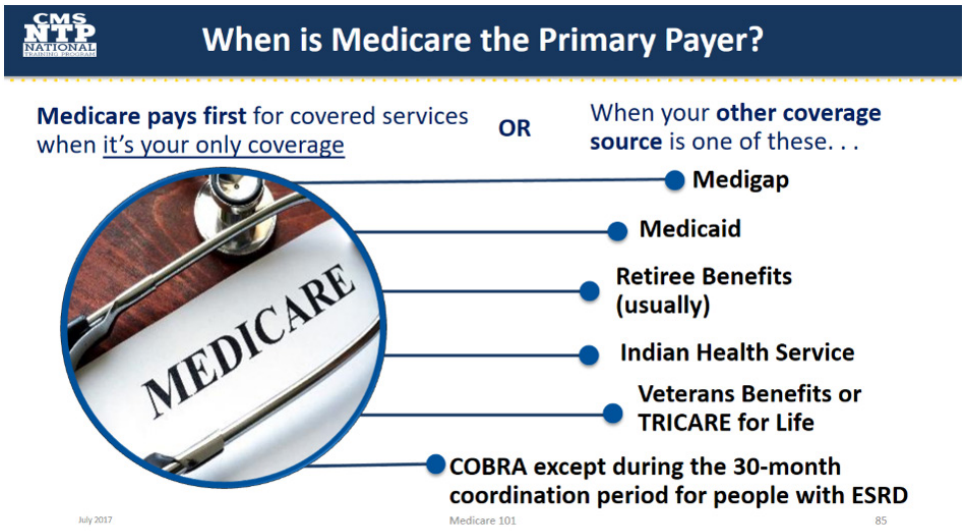
[Slide 85]



When is Medicare the Primary Payer?

Circle the Answer

Where text is underlined, circle the correct word or phrase.
See Appendix C for the answer key.

Medicare is the primary payer for **(all** or **most)** people with Medicare, which means Medicare pays **(first** or **second)** on their health care claims.

Medicare pays first when:

- Medicare is your **only source** of medical, hospital, or drug coverage, or
- Your **other source** of coverage is one or more of the following:
  - **A Medicare Supplement Insurance (Medigap) policy** or other privately purchased insurance policy that isn't related to current employment. A Medigap policy covers amounts not covered by Medicare.
  - **Medicaid and Medicare coverage** (dual eligible beneficiaries), with no other coverage that could be primary to Medicare.
  - **Retiree coverage,** in most cases. To know how a plan works with Medicare, check the plan's benefits booklet or plan description provided by the employer or union, or call the benefits administrator.
  - **The Indian Health Service**
  - **Veterans benefits**
  - **TRICARE** (TRICARE is the U.S. Department of Defense health program for active-duty service members and their families. TRICARE For Life is the program for military retirees and their families.)
  - **COBRA** (the Consolidated Omnibus Budget Reconciliation Act), except if you have End-Stage Renal Disease.

Notes

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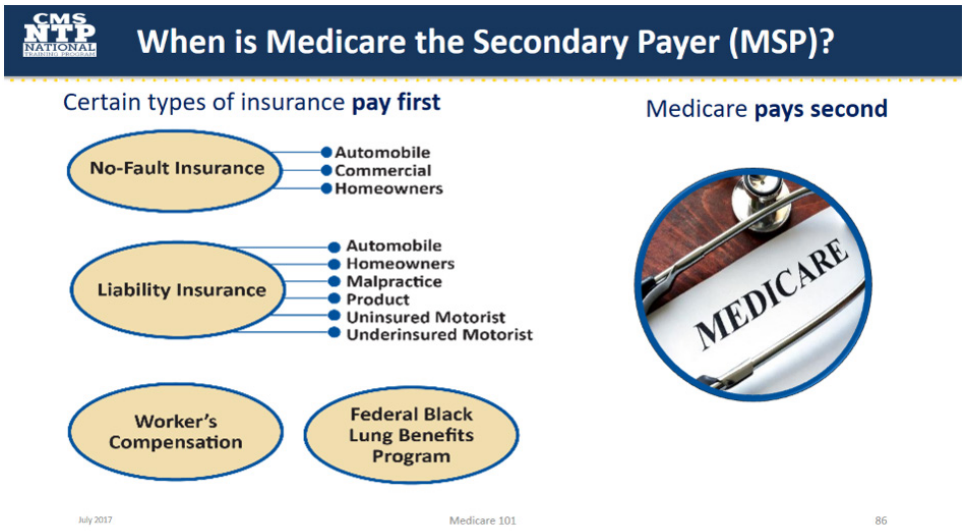
[Slide 86]



When is Medicare the Secondary Payer?

True or False

Select True or False for each of the following statements. See Appendix C for the answer key.

1. If Medicare makes a conditional payment it doesn't have to be repaid. **(True** or **False)**
2. Medicare won't pay for services needed unrelated to an automobile insurance claim until that claim is closed. **(True** or **False)**
3. For claims that involve homeowners no-fault or liability insurance, Medicare pays secondary. **(True** or **False)**

Medicare Secondary Payer (MSP) is the term generally used when Medicare isn't responsible for paying a claim first. As shown in the above illustration, Medicare is the secondary payer on claims that involve no-fault and liability insurance.

No-fault insurance is insurance that pays for health care services resulting from personal injury or damage to someone's property regardless of who's at fault for causing it. Types of no-fault insurance include automobile insurance, homeowners' insurance, and commercial insurance plans.

Medicare Secondary Payer (MSP) is the term generally used when Medicare isn't responsible for paying a claim first. As shown in the above illustration, Medicare is the secondary payer on claims that involve no-fault and liability insurance.

Medicare is the secondary payer when no-fault insurance is available. Medicare generally won't pay for medical expenses covered by no-fault insurance. However, Medicare may pay for medical expenses if the claim is denied for reasons other than not being a proper claim. Medicare will make payment only to the extent that the services are covered under Medicare. Also, if the no-fault insurance doesn't pay promptly (within 120 days), Medicare may make a conditional payment for which Medicare has the right to seek recovery.

The money that Medicare used for the conditional payment must be repaid to Medicare when the no-fault insurance settlement is reached. If Medicare makes a conditional payment and you later resolve the insurance claim, Medicare will seek to recover the conditional payment from you. You're responsible for making sure that Medicare gets repaid for the conditional payment.

The Medicare Modernization Act of 2003 (P.L. 108-173, Title III, Sec. 301) further clarifies language protecting Medicare's ability to seek recovery of conditional payments.

Part D plans will pay for covered prescriptions that aren't related to the accident or injury.

Liability insurance is coverage that protects you against claims based on negligence, inappropriate action, or inaction that results in injury to someone or damage to property. Liability insurance includes, but isn't limited to homeowners' liability insurance, automobile liability insurance, product liability insurance, malpractice liability insurance, uninsured motorist liability insurance, and underinsured motorist liability insurance.

Medicare is the secondary payer in cases where liability insurance is available. If health care professionals find that the services they gave a person can be paid by a liability insurer, they must attempt to collect from that insurer before billing Medicare. Providers are required to bill the liability insurer first, even though the liability insurer may not make a prompt payment. Sometimes this can take a long time. If the insurance company doesn't pay the claim promptly (usually within 120 days), your doctor or other provider may bill Medicare. Medicare may make a conditional payment for services for which another payer is responsible, so you won't have to use your own money to pay the bill. The payment is conditional because the person with Medicare is responsible for making sure Medicare is repaid when a settlement judgment, award, or other payment is made.

Learn more: For detailed examples of when Medicare is the secondary payer, view the "How Medicare Works With Other Coverage" chart in *Medicare and Other Health Benefits: Your Guide to Who Pays First* (Medicare.gov/Pubs/pdf/02179-Medicare-Coordination-Benefits-Payer.pdf).

How Medicare Secondary Payer (MSP) Provisions Protect Medicare

When Medicare started providing coverage in 1966, it was the primary payer for all claims except for those covered by workers' compensation, the Federal Black Lung Benefits Program, and the U.S. Department of Veterans Affairs.

In 1980, Congress passed legislation that made Medicare the secondary payer to certain primary plans in an effort to shift costs from Medicare to the appropriate private sources of payment.

The MSP provisions have protected Medicare's Trust Funds by making sure that Medicare doesn't pay for services and items that certain health coverage is primarily responsible for paying. The MSP provisions apply to situations when Medicare isn't the person's primary health insurance, or in situations where another entity has been identified as the primary payer.

Medicare saves almost $9 billion annually on claims processed by insurance that pay first before Medicare.

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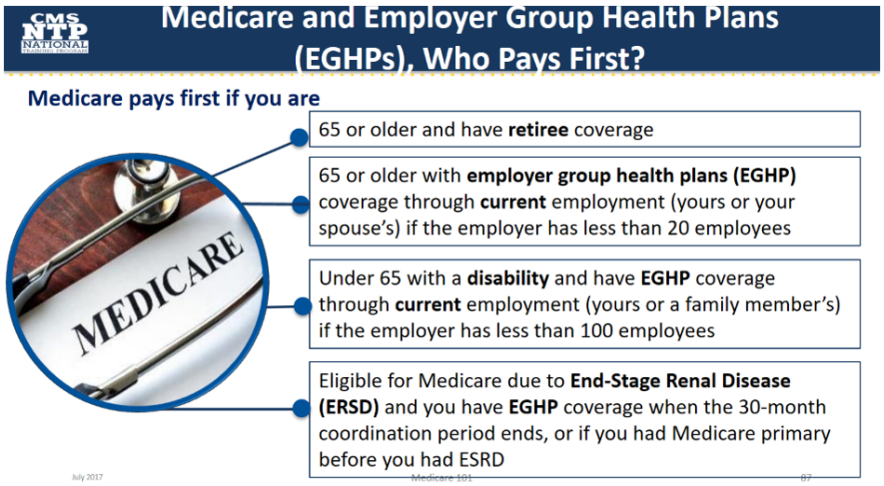
[Slide 87]



How Does Medicare Coordinate Benefits with Employer Group Health Plans (EGHPs)?

Medicare pays first for people with employer group health plans (EGHPs) if they're

- 65 or older and have retiree coverage
- 65 or older with EGHP coverage through current employment, either theirs or their spouse's, and the employer has less than 20 employees
- Under 65, have a disability, and are covered by an EGHP through current employment (either yours or a family member's), and their employer has less than 100 employees
- Eligible for Medicare due to End-Stage Renal Disease (ESRD) and they have EGHP coverage, either theirs or their spouse's, and the 30-month coordination period has ended, and they had Medicare as their primary coverage before they had ESRD

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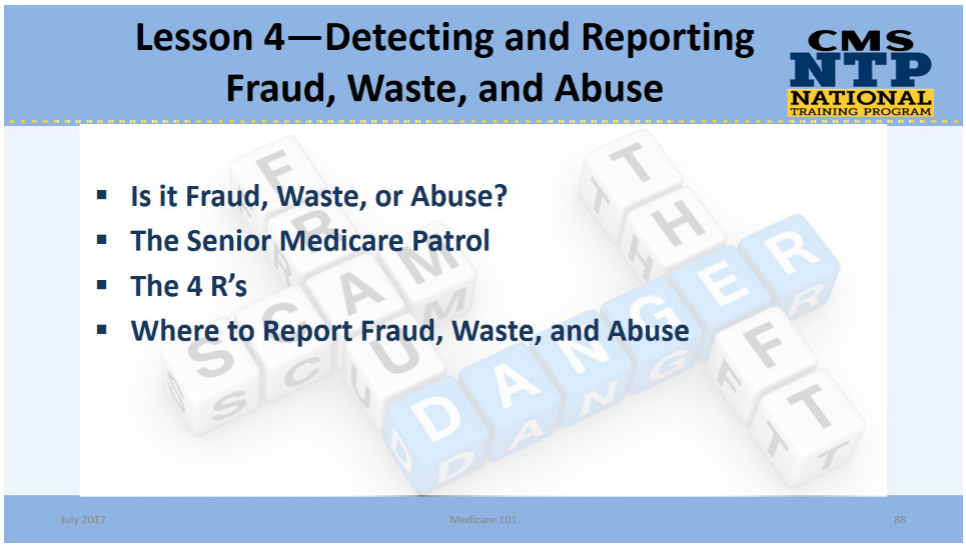
Lesson 4—Detecting and Reporting Fraud, Waste, and Abuse

[Slide 88]



This lesson should help you to understand fraud, waste, and abuse, including the following:

- Is it Fraud, Waste, or Abuse?
- The Senior Medicare Patrol
- The 4 R's
- Where to Report Fraud, Waste, and Abuse

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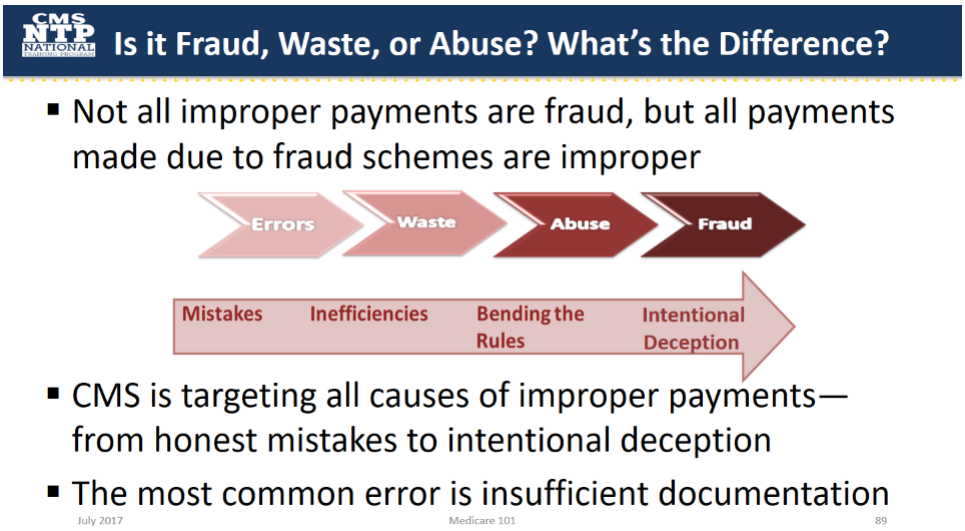
[Slide 89]



Is it Fraud, Waste, or Abuse? What's the Difference?

Match Game

Draw a line from each example (1-4) to its description (a-d) to indicate whether it is waste, abuse, fraud, or a mistake. See Appendix C for the answer key.

1. Billing for services that were not provided	a. Fraud
2. Incorrect coding	b. Waste
3. Upcoding	c. Mistakes
4. Ordering excessive tests	d. Abuse

Fraud, waste, and abuse are part of a spectrum of intention. At the lowest end of the spectrum are **mistakes**, such as incorrect coding, which can result in errors that lead to overpayment.

Waste can result from inefficiencies, such as ordering excessive tests.

Abuse is the next step on the spectrum. Abuse occurs when there's intentional deception, such as billing for supplies or services that weren't provided. Abuse is defined as when health care providers or suppliers perform actions that directly or indirectly result in unnecessary costs to any health care benefit program.

Fraud occurs when rules are bent and there are systematic intentional practices. Such practices could include upcoding, when a health care provider uses a billing code for a more expensive service than was performed. Fraud is defined as when someone intentionally deceives or makes misrepresentations to obtain money or property of any health care benefit program.

The primary difference between mistakes, waste, abuse, and fraud is intent.

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[Slide 90]

The Senior Medicare Patrol (SMP) Program

Find your local SMP program and record the contact information in the chart below.

Remember, there are three ways to find your local SMP program: (1) visit smpresource.org, (2) call 1-877-808-2468, or (3) call 1-800-MEDICARE (TTY: 1-877-486-2048).

My SMP Contact:

Name	Phone	Email	Organization Name

The SMP program educates and empowers people with Medicare to take an active role in detecting and preventing health care fraud, waste, and abuse. The SMP program not only protects people with Medicare, it also helps preserve Medicare.

Where SMP programs are located. Because this work often requires face-to-face contact to be most effective, SMPs nationwide rely on approximately 5,000 volunteers who are active each year to help in this effort. There's an SMP program in every state, the District of Columbia, Guam, the U.S. Virgin Islands, and Puerto Rico. Contact your local SMP program to get personalized counseling, find out about community events in your area, or volunteer. For more information or to find your local SMP program, visit smpresource.org, or call 1-877-808-2468. You can also call 1-800-MEDICARE (TTY: 1-877-486-2048).

Assistance to people with Medicare and Medicaid. In some cases, when people with Medicare and Medicaid are unable to act on their own behalf to address these problems, the SMPs work to address the problems, making referrals to the Centers for Medicare & Medicaid Services (CMS) and their anti-fraud contractors; the Office of Inspector General; state attorneys general offices; local law enforcement; State Health Insurance Assistance Programs; state insurance divisions; and other outside organizations that are able to intervene.

SMP liaisons. CMS established SMP liaisons in each Regional Office to serve as the point of contact for compliance/marketing issues identified by SMPs, to proactively engage with SMPs, and to share relevant program information, changes, and Medicare updates.

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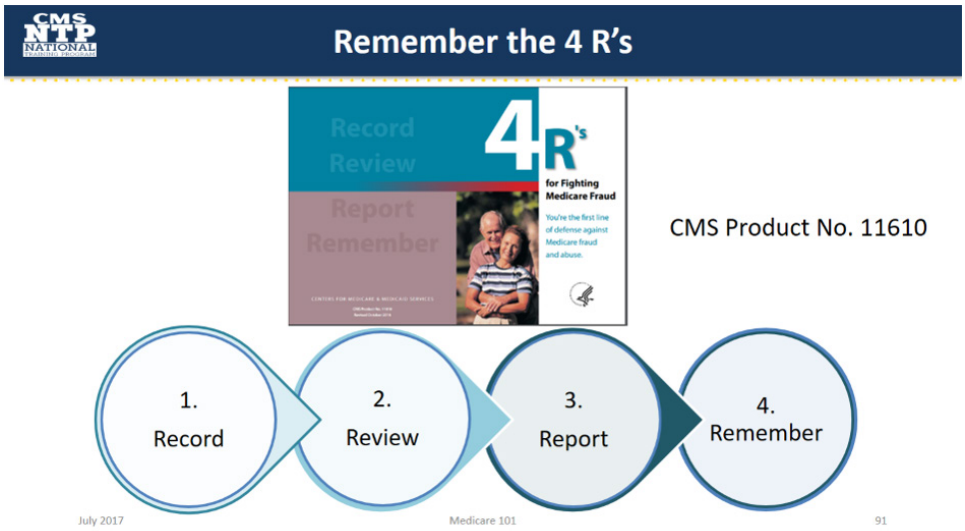
[Slide 91]



Remember the 4 R's

Fill in the Blanks *List the 4 R's in the correct order in the list below. See Appendix C for the answer key.*

1. _____
2. _____
3. _____
4. _____

People with Medicare can be the first line of defense against fraud, waste, and abuse. They're encouraged to follow the 4 R's: Record, Review, Report, and Remember.

CMS Product No. 11610, "4 R's for Fighting Medicare Fraud," is available at https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/4RsForFightingFraudAug2015.pdf.

NTP NATIONAL TRAINING PROGRAM MODULE 10

CMS Classroom Module 10—Medicare and Medicaid Fraud and Abuse Prevention: This self-paced individual learning tool covers Medicare and Medicaid fraud and abuse prevention, detection, reporting, and recovery strategies. See Appendix A for descriptions and links to this and other CMS Classroom Modules.

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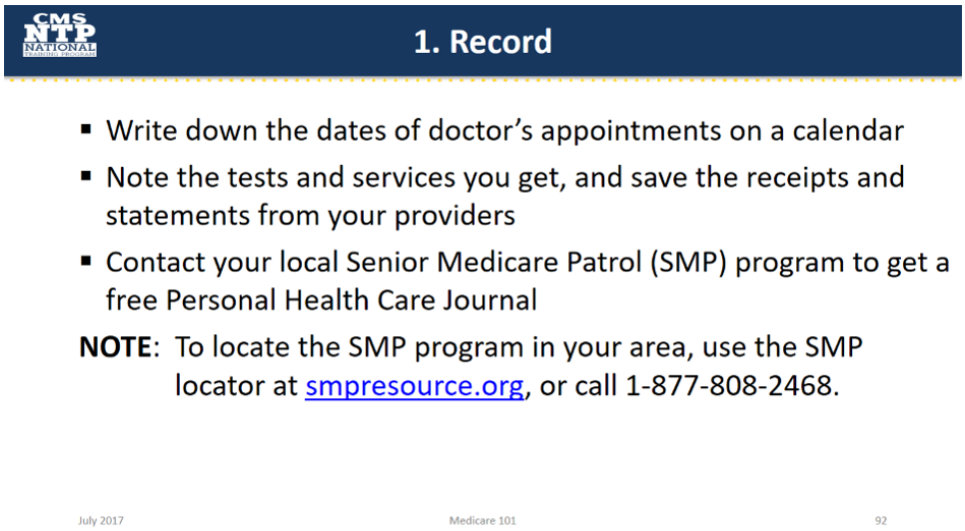
[Slide 92]



The First R: Record

Choose from the response options. See Appendix C for the answer key.
Response options: *dates, receipts, Senior Medicare Patrol (SMP), tests.*

Record the _____ of doctor's appointments on a calendar. Note the _____ and services you get, and save the _____ and statements from your providers. If you need help recording the dates and services, ask a friend or family member.

Contact your local _____ program to get a free Personal Health Care Journal.

To locate the SMP program in your area: Use the SMP locator at smpresource.org, or call 1-877-808-2468.

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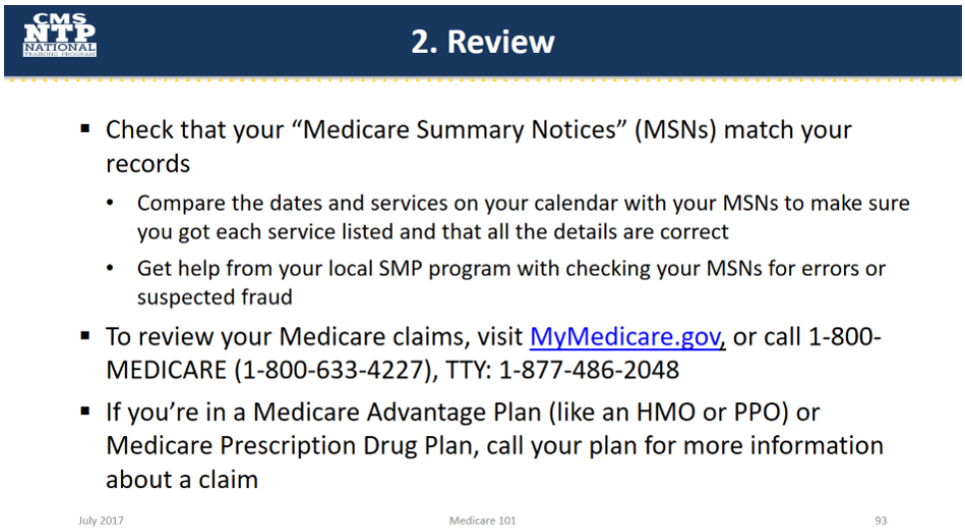
[Slide 93]



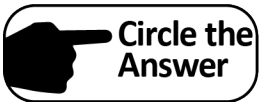
Where text is underlined, circle the correct word or phrase. See Appendix C for the answer key.

The Second R: Review

Look for signs of fraud, including claims you don't recognize on your Medicare Summary Notices (MSNs). Also, be wary of advertisements or phone calls from companies offering free items or services to people with Medicare.

Compare the dates and services on your calendar with your MSNs to make sure you got **(each service** or **most services)** listed and that **(all** or **most)** of the details are correct. If you find items listed in your claims that you don't have a record of, it's possible that you or Medicare may have been billed for services or items you didn't get.

To review your Medicare claims: Visit MyMedicare.gov or call 1-800-MEDICARE (1-800-633-4227) or TTY: 1-877-486-2048. If you're in a Medicare Advantage Plan (like an HMO or PPO) or a Medicare Prescription Drug Plan, call **(Medicare** or **your plan)** for more information about a claim.



To get help: Get help from your local Senior Medicare Patrol program with checking your MSNs for errors or suspected fraud.

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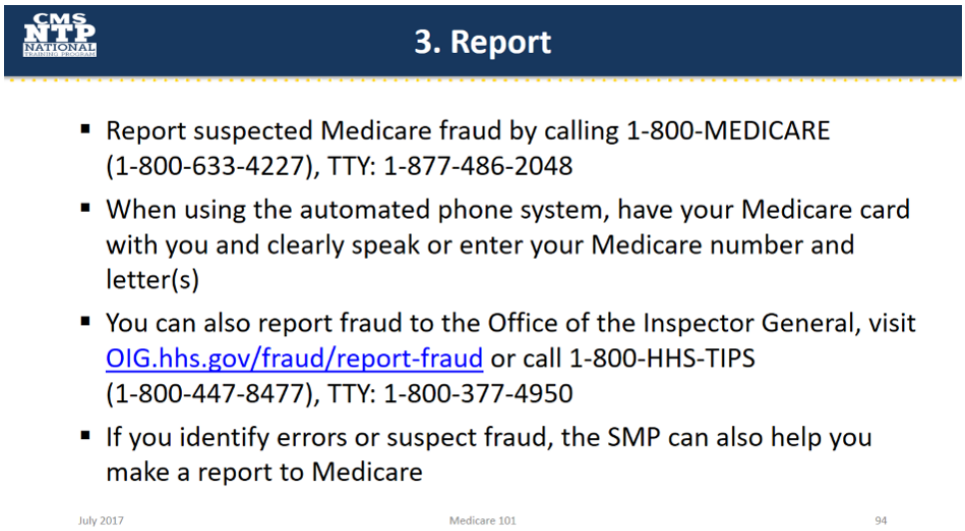
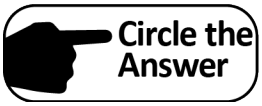
[Slide 94]



The Third R: Report



See Appendix C for the answer key.

How should you report suspected fraud?

a. Contact the Office of the Inspector General
b. Ask your local Senior Medicare Patrol (SMP) program to help you report it
c. Call 1-800-MEDICARE
d. Any of the above

There are three ways to report suspected Medicare fraud:

Call 1-800-MEDICARE (1-800-633-4227). When using the automated phone system, have your Medicare card with you, and clearly speak or enter your Medicare number and letter(s).

Contact the Office of the Inspector General. Visit OIG.hhs.gov/fraud/report-fraud or call 1-800-HHS-TIPS (1-800-447-8477). TTY: 1-800-377-4950.

Ask SMP for help. If you identify errors or suspect fraud, the SMP can help you make a report to Medicare.

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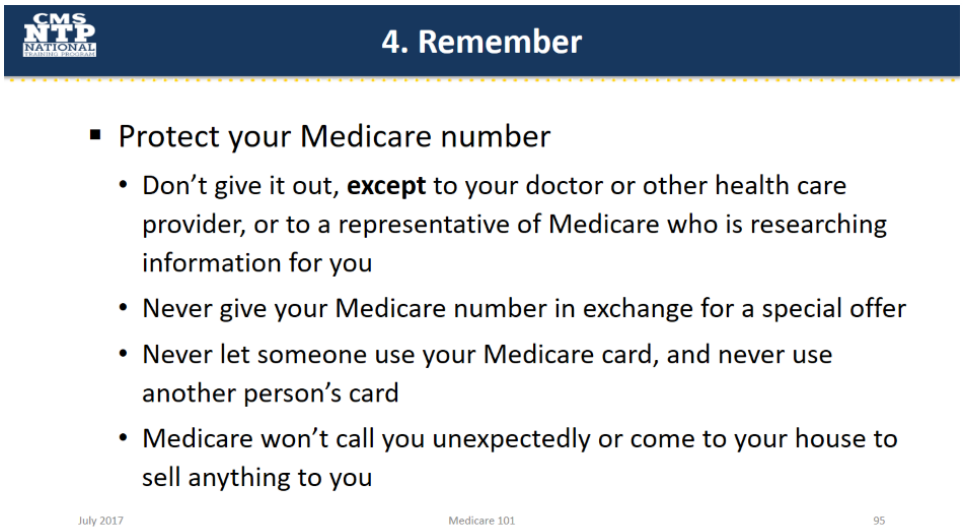
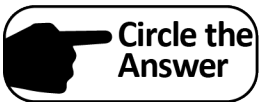
[Slide 95]



The Fourth R: Remember



Select Yes or No. See Appendix C for the answer key.

It's OK to give your Medicare number to the following people:

1. A casual friend **(Yes** or **No)**
2. Your doctor **(Yes** or **No)**
3. A person who calls with a special offer **(Yes** or **No)**
4. A salesperson who comes to your house **(Yes** or **No)**

Protect your Medicare number.

- Don't give it out, except to your doctor or other health care provider
- Never give your Medicare number in exchange for a special offer
- Never let someone use your Medicare card, and never use another person's card
- Know that Medicare won't call you unexpectedly or come to your house to sell you anything

Notes

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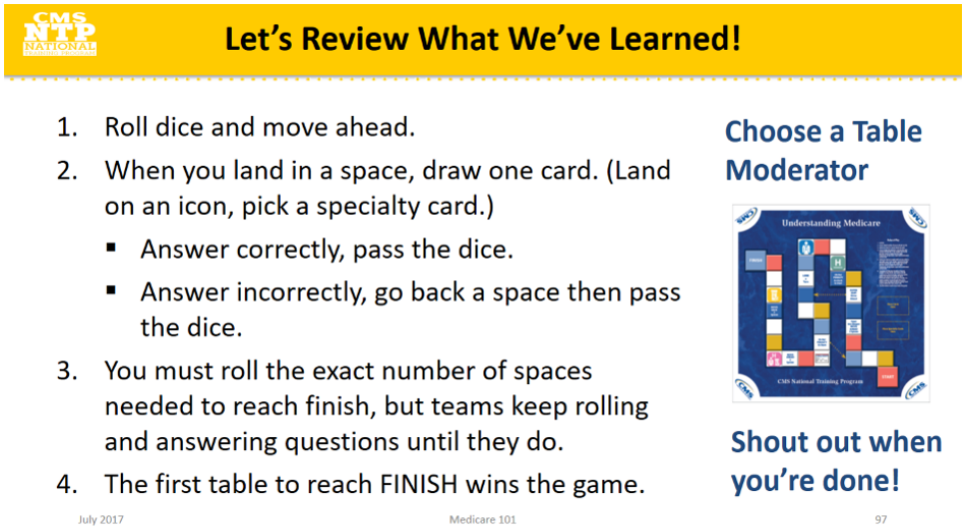
Lesson 5—Review

[Slide 96]

Now that you've learned about the basics of Medicare, coverage choices, coordination of benefits, and how to fight fraud, waste, and abuse, let's have an interactive review.

[Slide 97]



Let's Review What We've Learned!

Let's review what we've learned by playing a game. This game can be used to train others and to teach people with Medicare about their coverage.

Instructions

1. Roll dice.
2. Move ahead the number of spaces shown on dice.
3. When you land in a space, draw one card.
4. If you answer the question correctly, the next person rolls the dice. If you answer incorrectly, get the correct answer from the table moderator and go back a space before the next person rolls.
5. When you land on a space with an icon, select a specialty card. If you answer correctly, the next person rolls the die. If you answer incorrectly, get the correct answer from the table moderator and go back a space before the next person rolls.
6. You must roll the exact number of spaces needed to reach FINISH. Each player should continue to roll and answer a question until a player rolls the exact number to reach FINISH and answers the question correctly. If a player answers incorrectly, get the correct answer from the table moderator and go back a space before the next person rolls.
7. The first table to reach FINISH wins the game.
8. Shout out when you're done!

The review game board and question cards are available for download at https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/National-Training-Program-Resources.html. Select Medicare Learning Activities.

[Slide 98]

This Training is Provided by the CMS National Training Program (NTP)

To view all available NTP materials, or to subscribe to our email list, visit CMS.gov/outreach-and-education/training/CMSNationalTrainingProgram.

Contact us at training@cms.hhs.gov.

Follow us @CMSGov #CMSNTP.

Appendix A—Resources

This appendix contains links to resources that will help you further your own and others' understanding of Medicare. Here's what's included:

Medicare Classroom Modules

The Medicare Classroom Modules listed below are self-paced individual learning tools for partners, information givers, and trainers who share in-depth information about the Medicare program with people with Medicare. The modules include customizable train-the-trainer PowerPoint presentations with speaker notes, workbooks, and casework scenarios.
https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Classroom-Modules.html

Medicare 101: Medicare and the decisions people need to make when they select a Medicare option.
https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library-Items/CMS1248263.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

1 – Understanding Medicare: Hospital (Part A), medical (Part B), Medicare Advantage (Part C), and prescription drug (Part D) coverage in Medicare.
https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library-Items/CMS1190652.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=ascending

2 – Medicare Rights and Protections: Beneficiary rights.
https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library-Items/CMS1218199.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=ascending

3 – Medigap: Supplemental insurance policies that pay certain beneficiary health care costs that are not covered under Medicare.
https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library-Items/CMS026529.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=ascending

5 – Coordination of Benefits: Payers' responsibility when people have Medicare and certain other types of health and/or prescription drug coverage.
https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library-Items/CMS1239917.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

6 – Medicare for People with ESRD: For beneficiaries entitled to Medicare because of End-Stage Renal Disease or a disability.
https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library-Items/CMS026515.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=ascending

7 – Medicare Preventive Services: Medicare-covered services that help people with Medicare live longer and healthier lives, including why preventive services are important and who is eligible.
https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library-Items/CMS026513.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=ascending

8 – CMS Program Resources: Materials from CMS and the Social Security Administration as well as regulations to supplement information provided in the Medicare Modules.
https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library-Items/CMS-Program-Resources.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

9 – Medicare Part D Prescription Drug Coverage: Basic information about Medicare prescription drug coverage.
https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library-Items/CMS1202224.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=ascending

10 – Medicare and Medicaid Fraud and Abuse Prevention: Medicare and Medicaid fraud and abuse prevention, detection, reporting, and recovery strategies.
https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library-Items/CMS1248271.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

11 – Medicare Advantage Plans: A comprehensive overview of Medicare Advantage Plans, including who can join, when to join, how the plans work, and what you pay. A detailed lesson on marketing guidelines and the ways health plans may or may not market their plans.
https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library-Items/CMS1241850.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

12 – Medicaid & the Children's Health Insurance Program: For people with limited income and resources, including Medicaid, Medicare Savings programs, the Children's Health Insurance Program, and coverage in the U.S. territories.
https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library-Items/CMS1241651.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

13 – Medicare for People with a Disability: Topics include eligibility for Social Security programs, eligibility and enrollment in Medicare, Medicare plan options, Medigap policies, Medicaid, help paying health care costs, and sources for additional information.
https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library-Items/Medicare-and-Other-Programs-for-People-with-Disabilities.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=ascending

Medicare Information Resources

5-Star Plan Ratings

https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Downloads/2014-5-Star-Plan-Ratings-Overview-Job-Aid.pdf

This CMS National Training Program document explains plan ratings, including information about what they measure, how to learn more about them, the 5-star special enrollment period, and important considerations about prescription drug coverage when switching plans.

Changing from the Marketplace to Medicare

https://www.healthcare.gov/medicare/changing-from-marketplace-to-medicare/index.html

This HealthCare.gov website provides information about switching from a Marketplace plan to Medicare once your coverage starts.

Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare

https://www.medicare.gov/Pubs/pdf/02110-Medicare-Medigap.guide.pdf

This CMS guide includes important information about Medicare Supplement Insurance (Medigap) policies, what Medigap policies cover, your rights to buy a Medigap policy, and how to buy a Medigap policy.

CMS National Training Program (NTP)

https://www.cms.gov/outreach-and-education/training/cmsnationaltrainingprogram/index.html

This website provides an overview of the resources offered through the CMS National Training Program, including classroom modules, job tools, Web events, multimedia products, and train-the-trainer workshops.

Electronic Code of Federal Regulations

https://ecfr.gov/cgi-bin/text-idx?SID=4197918d7a58c79361d4f698fa25219e&mc=true&node=se42.2.411_120&rgn=div8

This section of the Electronic Code of Federal Regulations (42 C.F.R., Chapter IV, Section 411.20, Paragraph 2) includes information about exclusions from Medicare and limitations on Medicare payment.

Federal Trade Commission Complaint Assistant

https://www.ftccomplaintassistant.gov/#&panel1-1

The Federal Trade Commission Complaint Assistant can be used to report identity theft. You can also call 1-877-FTC-HELP (1-877-382-4357).

Health Savings Accounts and Other Tax-Favored Health Plans

https://www.irs.gov/pub/irs-pdf/p969.pdf

This IRS document contains important information for you to consider if you have a Health Savings Account.

How to Cancel Your Marketplace Plan

https://www.healthcare.gov/how-to-cancel-a-marketplace-plan/

For just the household contact
https://www.healthcare.gov/how-to-cancel-a-marketplace-plan/#household-contact
For just some people on your plan
https://www.healthcare.gov/how-to-cancel-a-marketplace-plan/#some

This HealthCare.gov website includes step-by-step instructions for canceling your Marketplace plan depending on your situation.

How to Compare Medigap Policies

https://www.medicare.gov/supplement-other-insurance/compare-medigap/compare-medigap.html

This Medicare.gov website provides information about how to compare Medigap policies and includes a chart illustrating basic information about the different benefits that Medigap policies cover.

How Medicare Prescription Drug Coverage Works with a Medicare Advantage Plan or Medicare Cost Plan

https://www.medicare.gov/Pubs/pdf/11135-Prescription-Drug-Coverage-with-MA-MCP.pdf

This CMS document explains the two ways to get Medicare prescription drug coverage—by joining a Medicare Prescription Drug Plan or by joining a Medicare Advantage Plan.

Introduction to the Consistent Poor Performer February Notice

https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/Feb2015_LPI_Notice_CMS-11633.pdf

This notice is sent to people who have recently enrolled in a plan that has been identified as a consistent poor performer to give them a one-time opportunity to switch to a higher rated plan. It is sent in February and includes important considerations about plan options and what to do next.

Joining a Health or Drug Plan

https://www.medicare.gov/sign-up-change-plans/when-can-i-join-a-health-or-drug-plan/when-can-i-join-a-health-or-drug-plan.html

This Medicare.gov website provides information about enrolling and making changes to coverage for your Medicare Advantage Plan (Part C) and/or Medicare prescription drug coverage (Part D).

Medicare Classroom Modules

https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Classroom-Modules.html

See the first section of this appendix for an annotated list of these online learning tools, with links to individual modules.

Medicare Outpatient Observation Notice (MOON)

https://www.cms.gov/medicare/medicare-general-information/bni/

The MOON is a standardized notice to inform Medicare beneficiaries (including health plan enrollees) that they are outpatients receiving observation services and are not inpatients of a hospital or critical access hospital. The MOON can be downloaded from this CMS website.

Medicare & Other Health Benefits: Your Guide to Who Pays First

https://www.medicare.gov/Pubs/pdf/02179.pdf

This CMS guide explains how Medicare works with other types of coverage, who should pay your bills first, and where to get more help.

Medicare & You: Different Parts of Medicare

https://www.youtube.com/watch?v=9w4n5M18fto&feature=youtu.be

This CMS video includes important information about the different parts of Medicare coverage.

Medicare Amounts

https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library-Items/CMS1253755.html?DLPage=1&DLEntries=10&DLFilter=Medicare%20Amounts%20&DLSort=0&DLSortDir=ascending

This CMS National Training Program page links to a document that provides current Medicare amounts for Part A, Part B, and Part D.

Medicare Coverage of Skilled Nursing Facility Care

https://www.medicare.gov/Pubs/pdf/10153.pdf

This CMS document explains Medicare-covered skilled nursing facility care, your rights and protections, and where you can get help with your questions.

Medicare Plan Finder

https://www.medicare.gov/find-a-plan/questions/home.aspx

This Medicare.gov website allows you to complete either a general or a personalized search for a Medicare plan.

Monthly Premium for Drug Plans

https://www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html

This Medicare.gov website explains monthly premiums for drug plans, including information about how to get your premium automatically deducted and Part D costs.

National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) Contacts

http://healthintegrity.org/contact-us/nbi-medic-contacts.html

Contact NBI MEDIC to report fraud related to Medicare Part C or Part D.

Obama Administration Announces Groundbreaking Public-Private Partnership to Prevent Health Care Fraud

https://www.justice.gov/opa/pr/obama-administration-announces-ground-breaking-public-private-partnership-prevent-health-care

This 2012 news release from the U.S. Department of Justice announced a collaborative effort between the federal government, state officials, several leading private health insurance organizations, and other organizations to prevent health care fraud.

Plan Finder Toolkit

https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library-Items/CMS1239988.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=ascending

The CMS Plan Finder Toolkit provides resources to help you navigate the Medicare Plan Finder. You can download a PowerPoint presentation with step-by-step instructions, as well as access Plan Finder video lessons.

Reporting Fraud

https://www.medicare.gov/forms-help-and-resources/report-fraud-and-abuse/report-fraud/reporting-fraud.html

This Medicare.gov website provides information about identifying and reporting suspected fraud.

Retirement Benefits

https://www.ssa.gov/pubs/EN-05-10035.pdf

This Social Security Administration document provides basic information on Social Security retirement benefits, including how you qualify for Social Security benefits, how your earnings and age can affect your benefits, what you should consider in deciding when to retire, and why you shouldn't rely on Social Security for all your retirement income.

Retirement Planner: Plan for Your Retirement

https://www.ssa.gov/planners/retire/index.html

This Social Security Administration website provides detailed information about Social Security retirement benefits and helps you plan for your future, whether you are looking for information or are already near retirement age.

Retirement Planner: Applying for Medicare Only

https://www.ssa.gov/planners/retire/justmedicare.html

This Social Security Administration website includes important considerations related to deciding whether to sign up for Medicare only and explains how waiting to apply for retirements benefits might affect you.

Senior Medicare Patrol (SMP)

https://www.smpresource.org/

This website helps you locate the SMP program in your area. SMPs aim to prevent Medicare fraud by conducting outreach and education, engaging volunteers, and receiving beneficiary complaints.

Social Security Office Locator

https://secure.ssa.gov/ICON/main.jsp

This website helps you find your local Social Security office. You need to enroll with Social Security if you're not automatically enrolled in Part A and Part B.

State Health Insurance Assistance Programs (SHIP)

https://www.shiptacenter.org/

The SHIPs offer free counseling and assistance for Medicare beneficiaries. This website allows you to search for your state SHIP.

Supplier Directory

https://www.medicare.gov/supplierdirectory/search.html

This Medicare.gov website allows you to search for suppliers of medical equipment and supplies, including Durable Medical Equipment, prostheses and prosthetic devices, and orthotics.

TRICARE

https://tricare.mil/mybenefit

This U.S. Department of Defense website provides information about TRICARE, a health care program for uniformed service members and their families.

U.S. Department of Veterans Affairs (VA)

https://va.gov/

This is the website for the VA. VA benefits are separate from Medicare. If you have VA benefits, you may choose to not enroll in Part B, but you pay a penalty if you don't sign up for Part B during your Initial Enrollment Period.

VHA Office of Community Care

https://www.va.gov/communitycare/

This U.S. Department of Veterans Affairs website provides information on community care for veterans. You must have Part A and Part B to keep your CHAMPVA coverage.

Your Guide to Medicare's Preventive Services

https://www.medicare.gov/Pubs/pdf/10110.pdf

This CMS document explains what disease prevention is and why it's important, which preventive services Medicare covers and how often, who can get services, and what you pay.

2016/2017 Plan Finder Training Scenarios

Training site URL: https://training.medicare.gov/?ACA=wU8YVKdS3e

Note: This website may load pages significantly slower than the public tool. It's generally available 7 a.m.–7 p.m. Eastern Time at least Monday through Friday.

The following test cases (referenced in Medicare 101, Lesson 2) should be used for personalized searches and are provided as a training tool for some beneficiary situations you may find when counseling.

1. Jane Smith has Original Medicare and no Low-Income Subsidy (LIS), also called Extra Help.
   - Zip: 55446
   - Medicare number: 111-11-1111A
   - Last name: Smith
   - Effective date, Part A, Feb. 1995
   - DOB: Jun. 15, 1930
2. John Stone is enrolled in a Prescription Drug Plan (PDP), has Original Medicare and a partial subsidy.
   - Zip: 33025
   - Medicare number: 333-33-3333A
   - Last name: Stone
   - Effective date, Part B, April 2005
   - DOB: April 15, 1940
3. Tom Jones has Original Medicare and no subsidy.
   - Zip: 50309
   - Medicare number: 555-55-5555A
   - Last name: Jones
   - Effective date, Part A, Aug. 1991
   - DOB: Aug 1, 1925
4. Kathy Johnson has a Medicare Advantage Plan and a partial subsidy.
   - Zip: 85018
   - Medicare number: 666-66-6666A
   - Last name: Johnson
   - Effective date, Part B, Nov. 1995
   - DOB: Sept. 6, 1940
5. Dan Martin is currently enrolled in Part D and also has future Part D enrollment. He qualifies for a full subsidy.
   - Zip: 11431
   - Medicare number: 222-22-2222BB
   - Last name: Martin
   - Effective date, Part A, Aug. 1998
   - DOB: Aug. 4, 1933
6. Tim Carpenter is currently enrolled in Original Medicare. He does not qualify for a subsidy.
   - 92841
   - Medicare number: 444-44-4444A
   - Last name: Carpenter
   - Effective date, Part A, May 1992
   - DOB: May 20, 1967

Appendix B—Glossary

Assignment

An agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

Benefits

The health care items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents.

Benefit period

The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you're admitted as an inpatient in a hospital or SNF. The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.

Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)

A health care benefit for dependents of qualifying veterans.

Children's Health Insurance Program (CHIP)

Insurance program jointly funded by state and federal government that provides health coverage to low-income children and, in some states, pregnant women in families who earn too much income to qualify for Medicaid but can't afford to purchase private health insurance coverage.

Claim

A request for payment that you submit to Medicare or other health insurance when you get items and services that you think are covered.

Coinsurance

An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Coordination of benefits

A way to figure out who pays first when 2 or more health insurance plans are responsible for paying the same medical claim.

This glossary of selected terms includes those referenced in the workbook. A comprehensive glossary of Medicare terms is available at https://www.medicare.gov/glossary/a.html.

Copayment

An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

Cost sharing

An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. This amount can include copayments, coinsurance, and/or deductibles.

Coverage gap (Medicare prescription drug coverage)

A period of time in which you pay higher cost sharing for prescription drugs until you spend enough to qualify for catastrophic coverage. The coverage gap (also called the "donut hole") starts when you and your plan have paid a set dollar amount for prescription drugs during that year.

Creditable coverage (Medigap)

Previous health insurance coverage that can be used to shorten a pre-existing condition waiting period under a Medigap policy.

Critical access hospital (CAH)

A small facility that provides outpatient services, as well as inpatient services on a limited basis, to people in rural areas.

Custodial care

Non-skilled personal care, like help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care.

Deductible

The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Demonstrations

Special projects, sometimes called "pilot programs" or "research studies," that test improvements in Medicare coverage, payment, and quality of care. They usually operate only for a limited time, for a specific group of people, and in specific areas.

This glossary of selected terms includes those referenced in the workbook. A comprehensive glossary of Medicare terms is available at https://www.medicare.gov/glossary/a.html.

Durable medical equipment

Certain medical equipment, like a walker, wheelchair, or hospital bed, that's ordered by your doctor for use in the home.

End-Stage Renal Disease (ESRD)

Permanent kidney failure that requires a regular course of dialysis or a kidney transplant.

Exception

A type of Medicare prescription drug coverage determination. A formulary exception is a drug plan's decision to cover a drug that's not on its drug list or to waive a coverage rule. A tiering exception is a drug plan's decision to charge a lower amount for a drug that's on its non-preferred drug tier. You or your prescriber must request an exception, and your doctor or other prescriber must provide a supporting statement explaining the medical reason for the exception.

Extra Help

A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, like premiums, deductibles, and coinsurance.

Formulary

A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

Generic drug

A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand-name drugs.

Group health plan

In general, a health plan offered by an employer or employee organization that provides health coverage to employees and their families.

Health care provider

A person or organization that's licensed to give health care. Doctors, nurses, and hospitals are examples of health care providers.

Health coverage

Legal entitlement to payment or reimbursement for your health care costs, generally under a contract with a health insurance company, a group health plan offered in connection with employment, or a government program like Medicare, Medicaid, or the Children's Health Insurance Program (CHIP).

This glossary of selected terms includes those referenced in the workbook. A comprehensive glossary of Medicare terms is available at https://www.medicare.gov/glossary/a.html.

Health Insurance Marketplace

A service that helps people shop for and enroll in affordable health insurance. The federal government operates the Marketplace, available at HealthCare.gov, for most states. Some states run their own Marketplaces.

The Health Insurance Marketplace (also known as the "Marketplace" or "exchange") provides health plan shopping and enrollment services through websites, call centers, and in-person help.

Homebound

To be homebound means:

- You have trouble leaving your home without help (like using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of an illness or injury; or
- Leaving your home isn't recommended because of your condition, and you're normally unable to leave your home because it's a major effort

You may leave home for medical treatment or short, infrequent absences for non-medical reasons, like attending religious services. You can still get home health care if you attend adult day care.

Home health care

Health care services and supplies a doctor decides you may get in your home under a plan of care established by your doctor. Medicare only covers home health care on a limited basis as ordered by your doctor.

Hospice

A special way of caring for people who are terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional, and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver.

Inpatient care

Health care that you get when you're admitted to a health care facility, like a hospital or skilled nursing facility.

Inpatient hospital care

Treatment you get in an acute care hospital, critical access hospital, inpatient rehabilitation facility, long-term care hospital, inpatient care as part of a qualifying research study, and mental health care.

Inpatient hospital services

Services you get when you're admitted to a hospital, including bed and board, nursing services, diagnostic or therapeutic services, and medical or surgical services.

This glossary of selected terms includes those referenced in the workbook. A comprehensive glossary of Medicare terms is available at https://www.medicare.gov/glossary/a.html.

Lifetime reserve days

In Original Medicare, these are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Long-term care

Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living, like dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living, or in nursing homes. Individuals may need long-term supports and services at any age. Medicare and most health insurance plans don't pay for long-term care.

Medicaid

A joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically necessary

Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Medical underwriting

The process that an insurance company uses to decide, based on your medical history, whether to take your application for insurance, whether to add a waiting period for pre-existing conditions (if your state law allows it), and how much to charge you for that insurance.

Medicare

Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Medicare Advantage Plan (Part C)

A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

This glossary of selected terms includes those referenced in the workbook. A comprehensive glossary of Medicare terms is available at https://www.medicare.gov/glossary/a.html.

Medicare Advantage Prescription Drug (MA-PD) Plan

A Medicare Advantage Plan that offers Medicare prescription drug coverage (Part D), Part A, and Part B benefits in one plan.

Medicare-approved amount

In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It may be less than the actual amount a doctor or supplier charges. Medicare pays part of this amount and you're responsible for the difference.

Medicare Cost Plan

A type of Medicare health plan available in some areas. In a Medicare Cost Plan, if you get services outside of the plan's network without a referral, your Medicare-covered services will be paid for under Original Medicare (your Cost Plan pays for emergency services or urgently needed services).

Medicare Health Maintenance Organization (HMO) Plan

A type of Medicare Advantage Plan (Part C) available in some areas of the country. In most HMOs, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. Most HMOs also require you to get a referral from your primary care physician.

Medicare health plan

Generally, a plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, and Demonstration/Pilot Programs. Programs of All-inclusive Care for the Elderly (PACE) organizations are special types of Medicare health plans. PACE plans can be offered by public or private entities and provide Part D and other benefits in addition to Part A and Part B benefits.

Medicare Medical Savings Account (MSA) Plan

MSA Plans combine a high deductible Medicare Advantage Plan and a bank account. The plan deposits money from Medicare into the account. You can use the money in this account to pay for your health care costs, but only Medicare-covered expenses count toward your deductible. The amount deposited is usually less than your deductible amount so you generally will have to pay out-of-pocket before your coverage begins.

Medicare Part A (Hospital Insurance)

Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B (Medical Insurance)

Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.

This glossary of selected terms includes those referenced in the workbook. A comprehensive glossary of Medicare terms is available at https://www.medicare.gov/glossary/a.html.

Medicare plan

Any way other than Original Medicare that you can get your Medicare health or prescription drug coverage. This term includes all Medicare health plans and Medicare Prescription Drug Plans.

Medicare Preferred Provider Organization (PPO) Plan

A type of Medicare Advantage Plan (Part C) available in some areas of the country in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Medicare prescription drug coverage (Part D)

Optional benefits for prescription drugs available to all people with Medicare for an additional charge. This coverage is offered by insurance companies and other private companies approved by Medicare.

Medicare Prescription Drug Plan (Part D)

Part D adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

Medicare Private Fee-For-Service (PFFS) Plan

A type of Medicare Advantage Plan (Part C) in which you can generally go to any doctor or hospital you could go to if you had Original Medicare, if the doctor or hospital agrees to treat you. The plan determines how much it will pay doctors and hospitals, and how much you must pay when you get care. A PFFS is very different than Original Medicare, and you must follow the plan rules carefully when you go for health care services. When you're in a PFFS Plan, you may pay more or less for Medicare-covered benefits than in Original Medicare.

Medicare SELECT

A type of Medigap policy that may require you to use hospitals and, in some cases, doctors within its network to be eligible for full benefits.

Medicare Special Needs Plan (SNP)

A special type of Medicare Advantage Plan (Part C) that provides more focused and specialized health care for specific groups of people, like those who have both Medicare and Medicaid, who live in a nursing home, or have certain chronic medical conditions.

This glossary of selected terms includes those referenced in the workbook. A comprehensive glossary of Medicare terms is available at https://www.medicare.gov/glossary/a.html.

Medicare Summary Notice (MSN)

A notice you get after the doctor, other health care provider, or supplier files a claim for Part A or Part B services in Original Medicare. It explains what the doctor, other health care provider, or supplier billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay.

Medigap basic benefits

Benefits that all Medigap policies must cover, including Part A and Part B coinsurance amounts, blood, and additional hospital benefits not covered by Original Medicare.

Medigap Open Enrollment Period

A one-time-only, 6-month period when federal law allows you to buy any Medigap policy you want that's sold in your state. It starts in the first month that you're covered under Part B **and** you're age 65 or older. During this period, you can't be denied a Medigap policy or charged more due to past or present health problems. Some states may have additional open enrollment rights under state law.

Medigap policy

Medicare Supplement Insurance sold by private insurance companies to fill "gaps" in Original Medicare coverage.

Network

The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.

Occupational therapy

Treatment that helps you return to your usual activities (like bathing, preparing meals, and housekeeping) after an illness.

Original Medicare

Original Medicare is a fee-for-service health plan that has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

Out-of-pocket costs

Health or prescription drug costs that you must pay on your own because they aren't covered by Medicare or other insurance.

Penalty

An amount added to your monthly premium for Part B or a Medicare drug plan (Part D) if you don't join when you're first eligible. You pay this higher amount as long as you have Medicare. There are some exceptions.

This glossary of selected terms includes those referenced in the workbook. A comprehensive glossary of Medicare terms is available at https://www.medicare.gov/glossary/a.html.

Physical therapy

Treatment of an injury or a disease by mechanical means, like exercise, massage, heat, and light treatment.

Pilot programs

See “demonstrations.”

Pre-existing condition

A health problem you had before the date that new health coverage starts.

Premium

The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive services

Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Programs of All-inclusive Care for the Elderly (PACE)

A special type of health plan that provides all the care and services covered by Medicare and Medicaid as well as additional medically necessary care and services based on your needs as determined by an interdisciplinary team. PACE serves frail older adults who need nursing home services but are capable of living in the community. PACE combines medical, social, and long-term care services and prescription drug coverage.

Referral

A written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don’t get a referral first, the plan may not pay for the services.

Rehabilitation services

Health care services that help you keep, get back, or improve skills and functioning for daily living that you’ve lost or have been impaired because you were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Religious nonmedical health care institution

A facility that provides nonmedical health care items and services to people who need hospital or skilled nursing facility care, but for whom that care would be inconsistent with their religious beliefs.

This glossary of selected terms includes those referenced in the workbook. A comprehensive glossary of Medicare terms is available at https://www.medicare.gov/glossary/a.html.

Secondary payer

The insurance policy, plan, or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other insurance depending on the situation.

Service area

A geographic area where a health insurance plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan's service area.

Skilled nursing care

Care like intravenous injections that can only be given by a registered nurse or doctor.

Skilled nursing facility (SNF) care

Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility (SNF).

State Health Insurance Assistance Program (SHIP)

A state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Supplier

Generally, any company, person, or agency that gives you a medical item or service, except when you're an inpatient in a hospital or skilled nursing facility.

TRICARE

A health care program for active-duty and retired uniformed services members and their families.

TRICARE For Life (TFL)

Expanded medical coverage available to Medicare-eligible uniformed services retirees age 65 or older, their eligible family members and survivors, and certain former spouses.

TTY

A TTY (teletypewriter) is a communication device used by people who are deaf, hard-of-hearing, or have severe speech impairment. People who don't have a TTY can communicate with a TTY user through a message relay center (MRC). An MRC has TTY operators available to send and interpret TTY messages.

Workers' compensation

An insurance plan that employers are required to have to cover employees who get sick or injured on the job.

This glossary of selected terms includes those referenced in the workbook. A comprehensive glossary of Medicare terms is available at https://www.medicare.gov/glossary/a.html.

Appendix C—Answer Key

Lesson 1

p. 1-2
What is Medicare?
Fill in the Blanks
1, 65, 24

p. 1-4
Agencies Responsible for Medicare
Fill in the Blanks
most, railroad, Office of Personnel Management, handle

p. 1-5
The 4 Parts of Medicare
Match Game
Part A–Hospital Insurance, Part B–Medical Insurance, Part C–Medicare Advantage, Part D–Medicare Prescription Drug Coverage

p. 1-7
Original Medicare: What Does Part A Cover?
Fill in the Blanks
190, 2

p. 1-10
Overview of Part A Costs for 2017
Match Game
1–b, 2–c, 3–a

p. 1-12
Are You an Inpatient or an Outpatient?
Circle the Answer
day before, 2, hasn't, may, 36th

p. 1-14
Check Your Knowledge—Inpatient/Outpatient (Jim)
True or False
False. Jim was not admitted until the third day. Although he spent 5 days (4 nights) in the hospital, only 3 were as an inpatient. His first 2 days would be billed as an outpatient, and his last 3 would be billed as an inpatient.

p. 1-15
Skilled Nursing Facility Care: Required Conditions for Coverage
Circle the Correct Answer
must, doesn't, longer, 30, is, must

p. 1-18
Paying for Skilled Nursing Facility Care
Match Game
1–c; 2–d; 3–b; 4–a

p. 1-19
Benefit Periods in Original Medicare
Circle the Answer
1–day, 2–60, 3–after, 4–Part A, 5–no, 6–can

p. 1-20
Check Your Knowledge—Benefit Periods (Michael)
True or False
False. Michael only paid one Part A deductible because he did not go for 60 days or more between his hospitalizations. Also, benefit periods can span over calendar years.

p. 1-21
Home Health Care Coverage
True or False
1–False: A home health care agency usually coordinates the services your doctor orders for you, 2–True, 3–False

p. 1-22
5 Required Conditions for Home Health Care Coverage
Circle the Answer
1–only one, 2–skilled, 3–skilled, 4–30, 5–must

p. 1-24
Paying for Home Health Care
Circle the Answer
nothing, Medicare, 60

p. 1-25
Check Your Knowledge—Is She Homebound? (Matsu)
True or False
True. You may leave home for medical treatment or short, infrequent absences for nonmedical reasons, like attending religious services. You can still get home health care if you attend adult day care.

p. 1-26
What Is Hospice Care?
True or False
1–False, 2–False: You must sign an election statement choosing hospice care, 3–True.

p. 1-29
Paying for Hospice Care
Circle the Answer
$5, 5%, $7.50, are, aren't

p. 1-32
Part B—What You Pay in 2017
Match Game
1–d, 2–b, 3–a, 4–c

1-35
Paying the Part B Premium
True or False
1–False. Retired federal employees should call the Office of Personnel Management. 2–False. Medicare bills people every 3 months if their retirement payments aren't enough to allow the Part B premium to be deducted from their monthly benefit payments.

1-36
Part B Cost Considerations
Circle the Answer
can, as long as you have Part B, July 1

p. 1-40
Check Your Knowledge #1—Part A or Part B?
Fill in the Blanks
B

p. 1-41
Check Your Knowledge #2—Part A or Part B?
Fill in the Blanks
A

p. 1-42
Check Your Knowledge #3—Part A or Part B?
Fill in the Blanks
B

p. 1-43
Check Your Knowledge #4—Part A or Part B?
Circle the Answer
isn't

p. 1-46
Medicare Enrollment
True or False
1–True; 2–False; 3–True

p. 1-47
Why Is Enrolling on Time Important?
Circle the Answer
more, 10%, years

p. 1-49
You Must Take Action to Enroll in Medicare When It's Not Automatic
Circle the Answer
4, 65, 3, 67, 62, 67

p. 1-51
Medicare Initial Enrollment Period (IEP)
Match Game
1–c, 2–a, 3–b

p. 1-56
Check Your Knowledge—Enrollment Periods
Circle the Answer
a–You'll need to wait until the next General Enrollment Period (January 1–March 31). You cannot sign up for Part A or Part B during the OEP (October 15–December 7).

p. 1-57
Automatic Enrollment Based on Disability
Circle the Answer
24, 5, 5, first

p. 1-62
When Coverage Starts for People with ESRD
Circle the Answer
first, fourth, 12, 3, first, 2

Lesson 2

p. 2-2
Your 2 Main Medicare Coverage Choices
Match Game
1–b, 2–a, 3–c

p. 2-3
Original Medicare
Fill in the Blanks
A, B, Medigap, D

p. 2-4
Medicare Supplement Insurance (Medigap)
True or False
1–True, 2–False, 3–False, 4–True

p. 2-5
Medigap Plans—Basic Benefits
True or False
1–False, 2–False

p. 2-6
Medigap Plans—Differences in Policies
Circle the Answer
2010; the same; Cost; A; can; Massachusetts, Minnesota, and Wisconsin

p. 2-7
Medigap Costs
Fill in the Blanks
premiums, age, where you live, company, nonsmokers, medical history, less, Plan F

p. 2-8
Check Your Knowledge—Medigap Policies
Circle the Answer
b–It depends on which state you live in.

p. 2-9
When You Can Buy a Medigap Policy
Circle the Answer
1–True, 2–True, 3–False

p. 2-13
Part D–Income-Related Monthly Adjustment Amount (Part D–IRMAA)
Circle the Answer
$85,000, $170,000, 2, in addition to, IRMAA

p. 2-14
Medicare Part D Considerations
Circle the Answer
A, B, won't, join, must, must, 2 drugs

p. 2-16
What Is Extra Help?
True or False
1–True, 2–False, 3–False, 4–True

p. 2-20
Who Can Join Part D?
True or False
1–False, 2–True, 3–False

p. 2-21
When You Can Join or Switch Plans
True or False
1–True, 2–False, 3–False, 4–False

p. 2-23
Special Enrollment Period to Join or Switch Part D Plan
Circle the Answer
8, 2

p. 2-25
Medicare Advantage Plans (Part C)
Circle the Answer
Part A and Part B, can't, can't

p. 2-26
Types of Medicare Advantage (Part C) Plans
Match Game
1–d, 2–b, 3–c, 4–f, 5–c, 6–e

p. 2-28
How Medicare Advantage Plans Work
Match Game
1–b, 2–c, 3–a

p. 2-31
When You Can Join or Switch Medicare Advantage Plans
True or False
1–True, 2–True

p. 2-33
When You Can Leave Medicare Advantage Plans
Circle the Answer
February 14, first, may not, will

p. 2-35
Medigap Policies Compared to Medicare Advantage Plans
Circle the Answer
don't, don't pay, must

p. 2-38
Marketplace and Becoming Eligible for Medicare
Circle the Answer
without, full, 3, won't, July

p. 2-39
Check Your Knowledge—Medicare/Marketplace (Maxine)
True or False
False

Lesson 3

p. 3-2
What Is Coordination of Benefits?
Circle the Answer
benefits, benefits

p. 3-3
What Determine Whether Medicare Pays First, Second, or Not at All?
Circle the Answer
don't, is, are

p. 3-4
When Is Medicare the Primary Payer?
Circle the Answer
most, first

p. 3-5
When Is Medicare the Secondary Payer?
True or False
1–False, 2–False, 3–True

Lesson 4

p. 4-2
Is It Fraud, Waste, or Abuse? What's the Difference?
Match Game
1–d, 2–c, 3–a, 4–b

p. 4-5
Remember the 4 R's
Fill in the Blanks
1–Record, 2–Review, 3–Report, 4–Remember

p. 4-6
The First R—Record
Fill in the Blanks
dates, tests, receipts, Senior Medicare Patrol (SMP)

p. 4-7
The Second R—Review
Fill in the Blanks
each service, all, your plan

p. 4-8
The Third R—Report
Circle the Answer
d–Any of the above

p. 4-9
The Fourth R—Remember
Circle the Answer
1–No, 2–Yes, 3–No, 4–No

Appendix D—Quick Reference Guide

This appendix contains infographics and charts on common Medicare issues and questions. You may want to keep these handy for easy reference—and to refresh your understanding of basic Medicare concepts. Here's what's included:

Use this just-in-time reference tool to find answers to common questions on the following Medicare-related topics:

- Enrollment
- Penalties
- Benefit Periods
- Skilled Nursing Facility Stays
- Inpatient vs. Outpatient
- Coordination of Benefits
- Disability and ESRD

They Handle Enrollment, Premiums, and Replacement Medicare Cards

We Handle the Rest

Social Security Administration (SSA) enrolls most people in Medicare

Railroad Retirement Board (RRB) enrolls railroad retirees in Medicare

Centers for Medicare & Medicaid Services (CMS) administers the Medicare Program

To avoid penalties from Medicare and the IRS…

Cancel contributions to your Health Savings Account (HSA) at least **6 months before** applying for Medicare.

and

Enroll in Medicare during your Initial Enrollment Period (IEP)* unless you (or your spouse) are actively working and enrolled in an Employer Group Health Plan (EGHP).

Enrolling on time is important because **if you don't . . .**

costs could be higher

Coverage might be affected, like having a **gap in coverage,** or a waiting period for a **pre-existing conditions**

Application for a Medigap policy could be **denied**

A Part A benefit period **ends** after 60 consecutive days…

Here

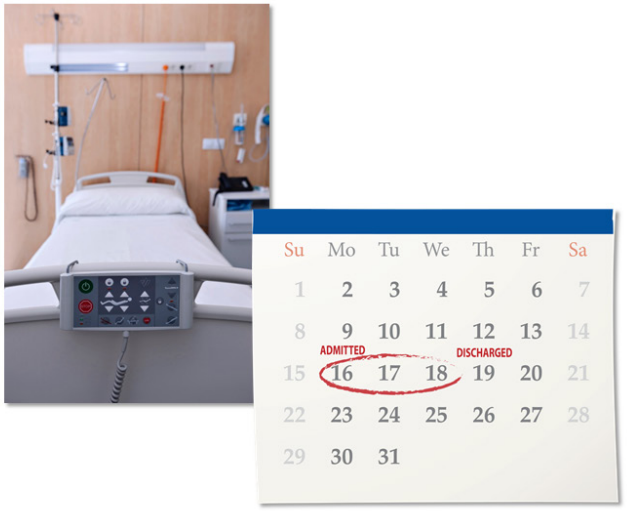
Home

…Not here

Hospital or Skilled Nursing Facility

Part A covers doctor-ordered skilled nursing facility care when

Inpatient stays are at least
3 consecutive days
(not including discharge day)
in a benefit period



For inpatient stays . . .

With doctor's orders:

Part A covers **inpatient** hospital services

Part B covers **doctor services**

Without doctor's orders:

Part A covers nothing for inpatient hospital stays

Part B covers **doctor** services and **outpatient** hospital services

Medicare pays first for covered services when it's your only coverage

OR

When your **other coverage source** is one of these. . .

- **Medigap**
- **Medicaid**
- **Retiree Benefits (usually)**
- **Indian Health Service**
- **Veterans Benefits or TRICARE For Life**
- **COBRA (with ESRD exception)**

Certain types of insurance **pay first** for related illness or injury

- **No-Fault Insurance**
  - Automobile
  - Commercial
  - Homeowners
- **Liability Insurance**
  - Automobile
  - Homeowners
  - Malpractice
  - Product
  - Uninsured Motorist
  - Underinsured Motorist
- **Worker's Compensation**
- **Federal Black Lung Benefits Program**

AND

Medicare **is Secondary Payer**

Keeping Medicare **Part B** is your choice, <u>unless</u> any of these apply to you.

You want to keep

You want to join a

You are eligible for

Your employer requires it

ELIGIBILITY: WAITING PERIOD FOR INDIVIDUALS WITH DISABILITIES

In **most** cases, you can receive Medicare based on a **disability** if you . . .

65

are **under** 65 and qualify for Medicare based on a disability

and

have been entitled to Social Security Disability Insurance benefits for **24 months***

To enroll in **Part A and Part B** because you have End-Stage Renal Disease **(ESRD)**

Get doctor/dialysis center to **complete Form CMS-2728**

Then, enroll at your local Social Security office

Check with your benefits administrator, but people with ESRD may want to **delay*** enrollment in **Part A and Part B if**

Most or all costs are covered by your employer or union group health plan (GHP)

And, you are still within the 30-month coordination period

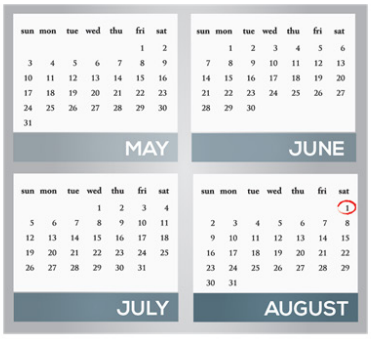
FOR MORE INFORMATION, SEE LESSON 1, PAGE 1-59

30-Month Coordination Period for people with ESRD

Starts the **first month** you're able to get Medicare, even if you don't enroll

Medicare **pays secondary** to an employer or union group health plan

For most individuals with End-Stage Renal Disease (**ESRD),** Medicare coverage begins…



Day 1 of 4th month of dialysis

For some individuals with **ESRD,** if they get a kidney transplant or meet specific home dialysis conditions, Medicare coverage begins…

Immediately or **Day 1 of 1st month of dialysis**

The 4 Parts of Medicare

Part A **Hospital Insurance**	• Inpatient Hospital Care–Semi-private room, meals, general nursing, other hospital services and supplies, as well as care in inpatient rehabilitation facilities and inpatient mental health care in a psychiatric hospital (lifetime 190-day limit) • Inpatient skilled nursing facility (SNF) care (not custodial or long-term care) after a related 3-day inpatient hospital stay if you meet all the criteria • Blood (inpatient) • Certain inpatient health care services in approved religious nonmedical health care institutions (RNHCIs) (e.g., nonreligious, nonmedical items and services) • Home health care • Hospice care
Part B **Medical Insurance**	• Doctors' services • Outpatient medical and surgical services and supplies • Clinical lab tests • Durable medical equipment • Diabetic testing supplies • Preventive services (like flu shots and a yearly wellness visit) • Home health services
Part C **Medicare Advantage (MA) Plans**	• Combines Parts A and B, and usually D (must have Part A and Part B) • Managed by private insurance companies approved by Medicare • Examples include Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) • In most MA Plans, you need to use the plan's network of doctors, hospitals, and other providers, or you pay more or all of the costs
Part D **Medicare Prescription Drug Coverage**	• Must have Medicare Parts A and/or B to join • Plans have formularies (lists of covered drugs) • Participants can choose plan and join

Medicare Enrollment: Who and When to Call

Remember: Centers for Medicare & Medicaid Services (CMS) administers Medicare.

To Enroll in Parts A and B	To Enroll in Parts C or D	When to Enroll
Most People: Social Security Administration (SSA) socialsecurity.gov 1-800-722-1213 (or local Social Security office) TTY 1-800-325-0778 **Railroad Retirees:** Railroad Retirement Board 1-877-772-5772	Medicare.gov 1-800-MEDICARE (1-800-633-4227) TTY: 1-877-486-2048 (or contact a Medicare-approved plan)	There are different enrollment periods for the various parts of Medicare. See "Medicare Enrollment Period Quick Reference" in the *Medicare 101 Workbook*, Appendix D.

A quick look at your Medicare coverage choices

There are 2 main choices for how you get your Medicare coverage.

Option 1: Original Medicare

This includes Part A and B.

Part A
Hospital Insurance

Part B
Medical Insurance

You can add:

Part D
Medicare Prescription Drug Coverage

You can also add:

Medigap
Medicare Supplement Insurance

(Medigap policies help pay your out-of-pocket costs in Original Medicare.)

Option 2: Medicare Advantage (Part C)

These plans are like HMOs or PPOs, and typically include Part A, B, and D.

Part A
Hospital Insurance

Part B
Medical Insurance

Part D
Medicare Prescription Drug Coverage

(Most plans cover prescription drugs. If yours doesn't, you may be able to join a separate Part D plan.)

Things to consider when choosing your Medicare coverage

These topics are explained in more detail throughout this book.

Original Medicare	⟷	Medicare Advantage
There's **no limit** on how much you pay out-of pocket per year unless you have supplemental coverage.	**Cost**	Plans have a **yearly limit** on your out-of-pocket costs. If you join a Medicare Advantage Plan, once you reach a certain limit, you'll **pay nothing** for covered services for the rest of the year.
Medicare **covers medical** services and supplies in hospitals, doctors' offices, and other health care settings. Services are either covered under Part A or Part B.	**Coverage***	Plans must cover all of the services that Original Medicare covers. Plans may **offer benefits** that Original Medicare doesn't cover like **vision, hearing, or dental**.
You **can add** a Medigap policy to help pay your out-of-pocket costs in Original Medicare, like your deductible and coinsurance.	**Supplemental coverage**	It may be more cost effective for you to join a Medicare Advantage Plan because your **cost sharing is lower (or included)**. You can't use (and can't be sold) a Medigap policy if you're in a Medicare Advantage Plan
You'll **need to join** a Medicare Prescription Drug Plan to get drug coverage.	**Prescription drugs***	Most Medicare Advantage Plans **include drug coverage**.
You can **go to any doctor** that accepts Medicare.	**Doctor and hospital choice**	You may need to use health care providers who participate in the **plan's network**. If so, find out how close the network's doctor or pharmacies are to your home. Some plans offer out-of-network coverage.
You can get a snapshot of the quality of care health care providers (and facilities) give their patients by visiting **Medicare.gov**.	**Quality of care**	The Medicare Plan Finder at **Medicare.gov/find-a-plan** features a **star rating system** for Medicare plans.
Original Medicare generally **doesn't cover care outside the U.S.** You may be able to buy supplemental insurance that offers travel coverage.	**Travel**	Plans **usually don't cover care** you get outside of the U.S.

* If you have other types of health or prescription drug coverage, check to see how it works with the type of coverage you're considering before you make any decisions or changes.

Medigap Plan Types

	Medicare Supplement Insurance (Medigap) Plans									
Benefits	**A**	**B**	**C**	**D**	**F***	**G**	**K**	**L**	**M**	**N**
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%***
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%	75%	50%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	100%	100%
Part B deductible			100%		100%					
Part B excess charges					100%	100%				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
Out-of-Pocket Limit in 2017**							$5,120	$2,560		

*Plan F is also offered as a high-deductible plan by some insurance companies in some states. If you choose this option, this means you must pay for Medicare-covered costs (coinsurance, copayments, deductibles) up to the deductible amount of $2,200 in 2017 before your policy pays anything.
**For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible ($183 in 2017), the Medigap plan pays 100% of covered services for the rest of the calendar year.
***Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in an inpatient admission.

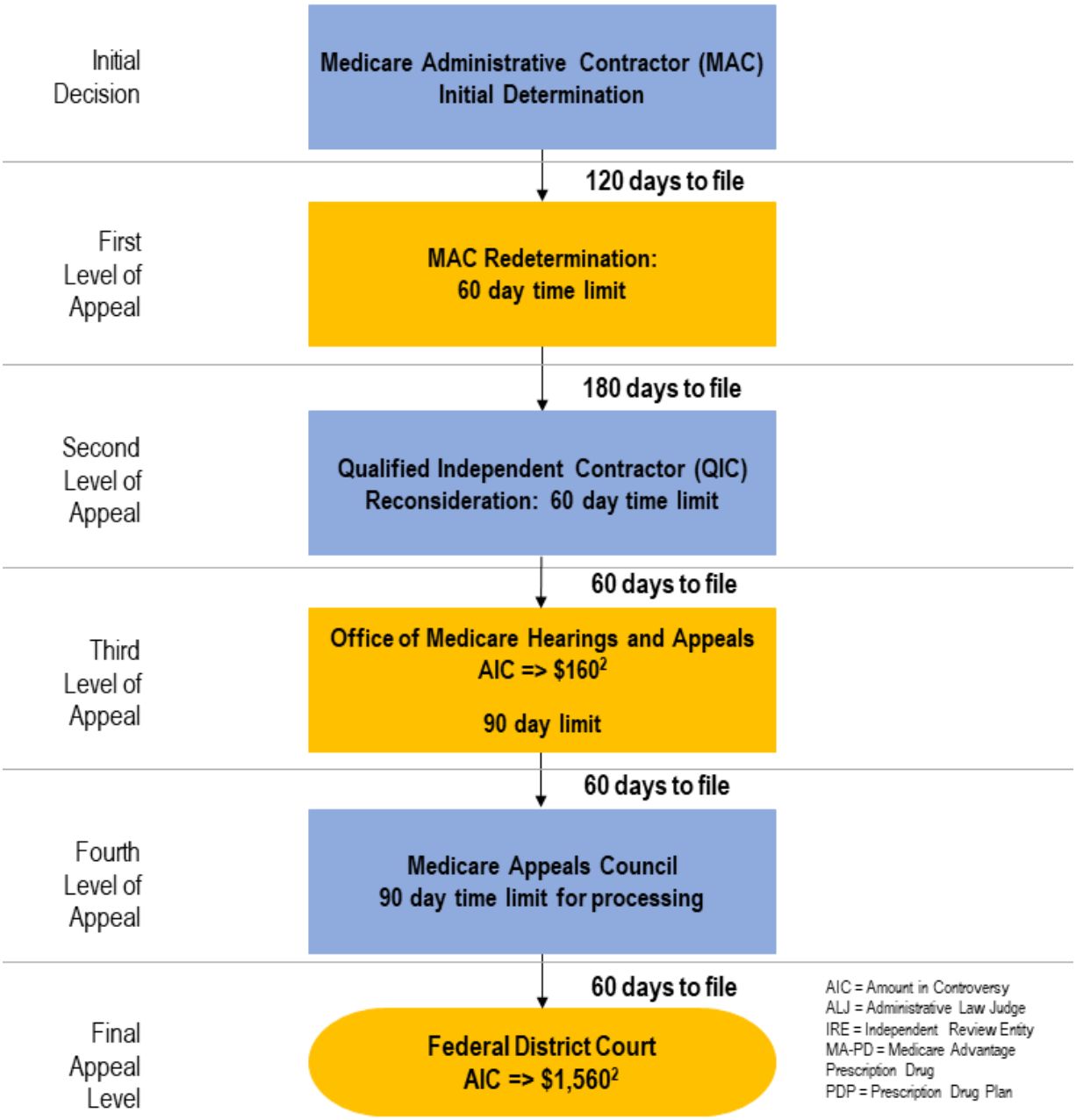
Medicare Enrollment Period Quick Reference

Period	Part A (Hospital Insurance)	Part B (Medical Insurance)	Part C Medicare Advantage (MA)	Part D Medicare Prescription Drug Coverage
Initial Enrollment (IEP)	7-month period including the 3 months before, the month of, and the 3 months after your month of Medicare Eligibility			
General Enrollment (GEP)	January 1 – March 31, annually (coverage will start July 1)		If you enroll in both Part A and Part B during the GEP, you can enroll in an MA Plan, MA-PD Plan, or Medicare Part D plan from April – June (coverage starts July 1). If you had Part A, and enroll in Part B during the GEP, you wouldn't be able to join a stand-alone Part D plan (you missed your Part D IEP). You could enroll in an MA or MA-PD Plan.	
Special Enrollment (SEP)	Starts while you or your spouse are working and have employer group coverage based on that active employment, and the 8-month period that starts the month after the employment or employer group coverage ends, whichever occurs first.		This depends on the reason you qualify for an SEP.	
Fall Open Enrollment (OEP)	Not Applicable	Not Applicable	October 15 – December 7, annually (coverage will start January 1)	
Medicare Advantage Disenrollment	Not Applicable	Not Applicable	January 1 - February 14, annually	January 1 – February 14, annually. (If you leave your MA Plan and return to Original Medicare, you can usually join a stand-alone drug plan at that time.)

This chart provides general information. It is not comprehensive.

2017 Comparison of the Parts A, B, C, and D Appeal Processes

Part A & Part B (Fee-For-Service) Standard Process

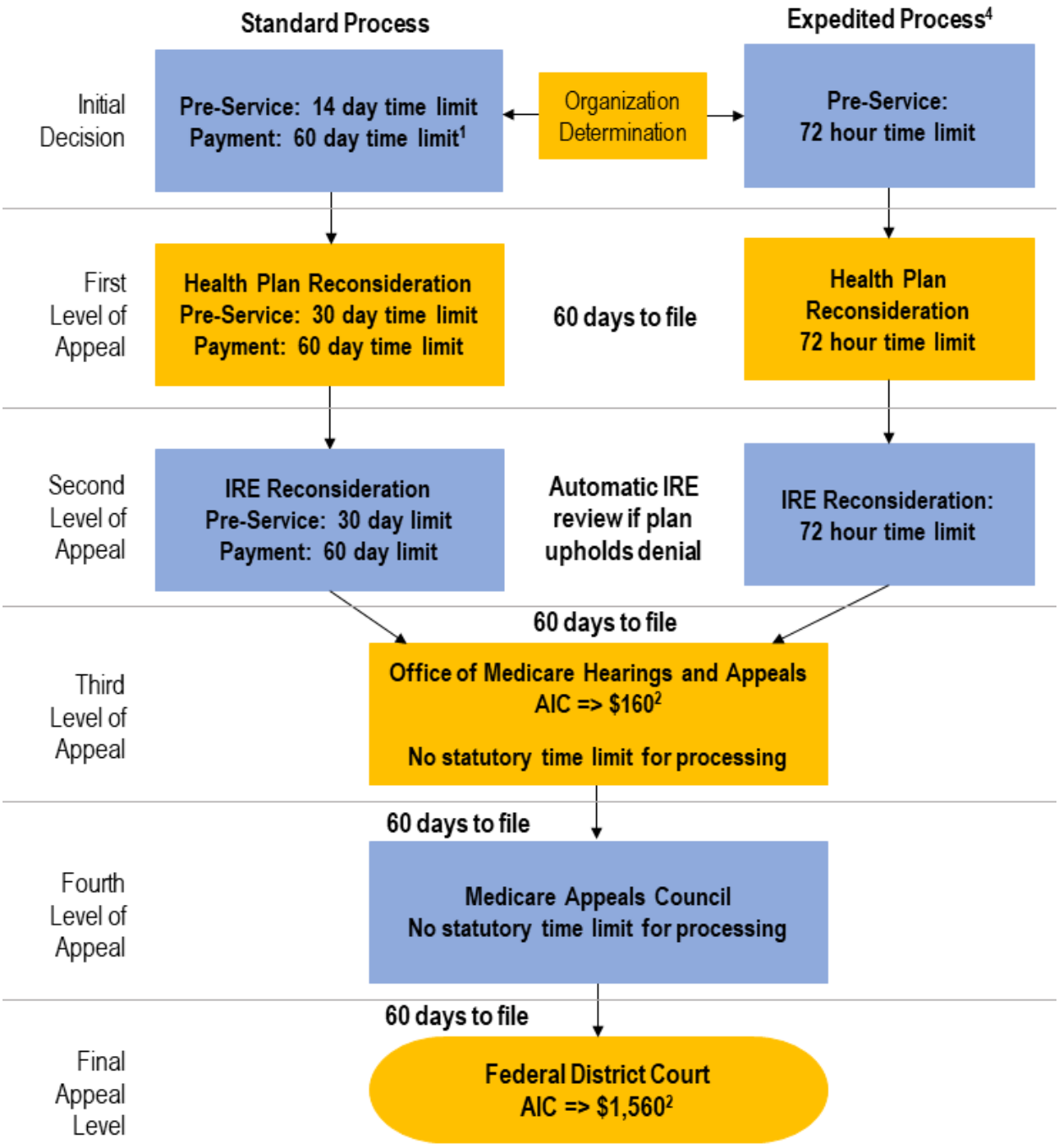


AIC = Amount in Controversy
ALJ = Administrative Law Judge
IRE = Independent Review Entity
MA-PD = Medicare Advantage Prescription Drug
PDP = Prescription Drug Plan

1: Plans must process 95% of all clean claims from out-of-network providers within 30 days. All other claims must be processed within 60 days.
2: The AIC requirement for an ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index. The chart reflects the CY 2017 AIC amounts.
3: A request for a coverage determination includes a request for a tiering exception or a formulary exception. The adjudication timeframes generally begin when the request is received by the plan sponsor. However, if the request involves an exception request, the adjudication timeframe begins when the plan sponsor receives the physician's supporting statement.
4: Payment requests cannot be expedited.

2017 Comparison of the Parts A, B, C, and D Appeal Processes

Part C (MA) Process



2017 Comparison of the Parts A, B, C, and D Appeal Processes